UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD
REGION 10, SUBREGION 11

MH Hospital Manager, LLC, Employer, and NATIONAL NURSES ORGANIZING COMMITTEE/NATIONAL NURSES UNITED (NNOC/NNU), Petitioner.	)	Case 10-RC-257615

POST-HEARING BRIEF BY PETITIONER
NATIONAL NURSES ORGANIZING COMMITTEE/NATIONAL NURSES UNITED (NNOC/NNU)

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I. INTRODUCTION

As a matter of law, a petition for all registered nurses ("RNs") at an acute-care hospital is an appropriate unit under the Health Care Rule. This is an appropriate unit even if the petition does not include RNs at the employer's nonacute clinics that are merely a stone's throw from the hospital or even attached to it. All RNs at an acute-care hospital is exactly the type of unit for which the Union National Nurses Organizing Committee/National Nurses United ("NNOC" or the "Union") petitioned.

For the Employer MH Hospital Manager, LLC ("Employer") to prevail in showing that the petitioned-for unit is inappropriate, it has multiple heavy burdens. Not only does the Employer simply fail to meet these difficult tests, it has waived many of its arguments by failing to raise as issues in its Statement of Position the status of the petitioned-for facility as an acute-care hospital or that the petitioned-for unit is a single facility.

First, it must show that there are "extraordinary circumstances" that makes a petition for an acute-care hospital inappropriate. This is an extraordinarily limited exception to the Health Care Rule's pronouncement that petitions for all RNs at acute-care hospitals are appropriate units. To prevail, the Employer must establish that its argument for the inclusion of nonacute facilities is so different from the arguments the National Labor Relations Board ("NLRB" or the "Board") considered during rulemaking that application of the Health Care Rule is not feasible or sensible. Regions that have faced the same fact patterns, i.e., an employer arguing that a unit must add nonacute facilities to a unit of acute-care facilities, have roundly rejected the Employer's arguments.

If the Employer is somehow able to show extraordinary circumstances, which it cannot, the Employer must then prove that the employees it seeks to add from the nonacute facilities were arbitrarily excluded from the single-facility unit. Because there is a unique distinction between

acute-care and nonacute-care RNs, the Employer cannot show that the exclusion was arbitrary.

The Employer also has the very heavy burden to prove that it along with two separate employer entities constitute a single-integrated employer to add additional employees, namely provider-level Certified Registered Nurse Anesthetists ("CRNA") and Nurse Practitioners ("NP"). Unable to show that there is any cross supervision between the entities, the Employer cannot establish the three entities are a single employer.

Put simply, the Health Care Rule compels a finding that the petitioned-for unit of all registered nurses at the acute-care hospital is appropriate, and the Region should immediately direct an election for this unit.

II. RELEVANT FACTS

Mission Hospital is an acute-care hospital located at 509/428 Biltmore Ave., Asheville, North Carolina in Buncombe County. Tr. Vol. 2, at pp. 35 & 39; Pet'r Ex. 17. HCA, the largest for-profit hospital chain in the country, acquired Mission Hospital in or about February 2019. *Id.* at 46. This acute-care hospital is part of the HCA North Carolina Division, which includes several acute[1] and nonacute facilities throughout the State of North Carolina. *Id.*

MH Hospital Manager, LLC ("MHHM") employs the RNs that work at the acute-care hospital. Bd. Ex. 3 Att. B; *see also* Emp'r Ex. 3. NNOC/NNU petitioned to represent this unit of workers. Bd. Ex. 1(a). MHHM also employs employees at several nonacute outlying clinics, for which the Union did not petition to represent.

MH Asheville Specialty Hospital, LLC ("MHASH") employs RNs at the Long-Term Acute Care Hospital ("LTACH"), which is located on the fourth floor of the 428 Biltmore acute-

[1] The only acute-care facility at issue in the instant matter is the petitioned-for location at 509/428 Biltmore Ave. The Employer did not propose to add its other acute care facilities that are at a great distance from the petitioned-for hospital, e.g., McDowell Hospital In Marion, NC and Transylvania Hospital in Brevard, NC.

care location. Pet'r Ex. 16. LTACH has a distinct supervisory structure from the other employer entities, Tr. Vol. 5, at p. 541, and has a separate license for "general acute" care beds than Mission Hospital, Pet'r Ex. 16; Emp'r Ex. 18. The average length of patient stay at LTACH is 25 days. Tr. Vol. 5, at p. 533. The Union did not petition for employees employed by MHASH.[2]

MH Community Multispecialty Providers, LLC ("MHCMP") employs HCA North Carolina Division's physicians and other advanced practitioners, such as Certified Registered Nurse Anesthetists ("CRNA"), Nurse Practitioners ("NP"), and Physician Assistants. Emp'r Ex. 4; Tr. Vol. 7, 829. MHCMP employees work at HCA North Carolina Divisions' acute and nonacute facilities. Bd. Ex. 3, Atts. B & C. MHCMP has a separate supervisory structure from the other employer entities. Pet'r Exs. 7 & 9; Tr. Vol. 7, at p. 763 & 829–30; Tr. Vol. 8 at p. 875; Tr. Vol. 10, at 1190 & 1206; Emp'r Ex. 20, at 000426. The Union did not petition for employees employed by MHCMP.[3]

On March 6, 2020, the Union filed an RC Petition to represent all registered nurses at the Employer's singled-facility, acute-care hospital. Bd. Ex. 1(a) (Questions 4a & 5). Specifically, it petitioned for "All full-time, regular part-time, and per diem Registered Nurses, employed by the Employer at its facility located at 509 Biltmore Ave., Asheville, NC 28801 and 428 Biltmore Ave., Asheville, NC 28801." *Id.* Att. A (Question 5). It sought to exclude "All other employees, guards, supervisors and other professional employees as defined in the Act." *Id.*

The Employer filed its Statement of Position on April 7, 2020. Bd. Ex. 3. The Employer did not raise in its Statement of Position as an issue the status of the petitioned-for facility as an

[2] If the Region were to find a single employer, the Union would proceed to an election of a unit that included RNs employed by MHASH located at the acute-care hospital.

[3] If the Region were to find a single employer, the Union would proceed to an election of a unit that included CRNAs and NPs employed by MHCMP located at the acute-care hospital.

acute-care hospital or its status as a single facility; nor did it attempt to raise these issues at hearing. Rather, it claims that the petitioned-for unit is inappropriate primarily because it excludes RNs "who do not have a distinct community of interest from [RNs] included in the unit proposed by the petitioner," "fails to include all RNS in the Employer's integrated enterprise operating in Buncombe County" namely MHHM, MHCMP, and MHASH, and "fails to include [RNs] who share a community of interest with RNs included in the unit proposed by the petitioner." *Id.* at 2.

A hearing was held, commencing on April 14, 2020 and ending on May 6, 2020.

The Union seeks a decision on the appropriateness of its petitioned-for unit of all registered nurses at the acute-care hospital located at 509/428 Biltmore and a direction of a mail-ballot election as soon as practicable.

III. LEGAL ARGUMENT

According to the Health Care Rule, the Union's petition for all RNs at the Employer's acute-care hospital is appropriate, and the Employer cannot prove "extraordinary circumstances" to overcome its appropriateness. The petitioned-for unit is also presumptively appropriate under the single-facility presumption, which the Employer failed to challenge. Even if the single-facility presumption did not apply, the petitioned-for unit is appropriate because there is no arbitrary exclusion of RNs. The Employer failed to prove that it, along with two separate employer entities, is a single-integrated employer. The Region should order a mail-ballot election due to the Covid-19 crisis.

A. The Petitioned-For Unit of Registered Nurses at an Acute-Care Hospital Is Appropriate Under the Health Care Rule, and the Employer Cannot Show "Extraordinary Circumstances" Justifying Modification.

According to the Health Care Rule, the Union's petitioned-for unit of all RNs at the Employer's acute-care hospital is an appropriate unit, and the Employer cannot show "extraordinary circumstances" to justify modification. The Health Care Rule sets out the

appropriate units for acute-care hospitals, stating:

> This portion of the rule shall be applicable to acute care hospitals . . . Except in extraordinary circumstances and in circumstances in which there are existing non-conforming units, the following shall be appropriate units, and the only appropriate units, for petitions filed pursuant to section 9(c)(1)(A)(i) or 9(c)(1)(B) of the National Labor Relations Act, as amended, except that, if sought by labor organizations, various combinations of units may also be appropriate:
>
> (1) All registered nurses.
> (2) All physicians.
> (3) All professionals except for registered nurses and physicians.
> (4) All technical employees.
> (5) All skilled maintenance employees.
> (6) All business office clerical employees.
> (7) All guards.
> (8) All nonprofessional employees except for technical employees, skilled maintenance employees, business office clerical employees, and guards.

29 C.F.R. § 103.30(a). The Health Care Rule compels a finding that the Union's petitioned-for unit of all RNs is appropriate because it is for an undisputed acute-care hospital, and the Employer has not shown "extraordinary circumstances" justifying modification.

1. It Is Undisputed that the Union Petitioned for All RNs at the Employer's Acute-Care Hospital.

The Board's Health Care Rule applies because it is undisputed that the Union petitioned for all registered nurses at the Employer's acute-care hospital. In its RC Petition, the Union petitioned for all registered nurses employed by the Employer located at 509/428 Biltmore Ave., Asheville, NC 28801, stating that the "Type of Establishment" is an "Acute Care Hospital." Bd. Ex. 1(a) (questions 2b and 4a). The Employer never disputed that the location in question is an acute-care hospital in its Statement of Position. *See* Bd. Ex. 3. In fact, the Employer's first

witness testified that the petitioned-for locations constitute the Employer's acute-care hospital. Tr. Vol. 2, at p. 35 ("[T]he history of Mission Hospital is adjoining of two hospitals, St. Joseph's and Memorial Mission back in the late '90s. . . . So we are two **acute care hospitals**." (emphasis added)) (testimony of Joseph Rudisill).[4]

The Employer's failure to raise as an issue whether the petitioned-for locations constituted an acute-care hospital such that the Health Care Rule applies is dispositive. The Board Rules and Regulations require the Employer to describe all issues that it intends to raise at the hearing. 29 C.F.R. § 102.63(b)(1)(i). Further, "A party shall be precluded from raising any issue . . . and presenting argument concerning any issue that the party failed to raise in its timely Statement of Position." *Id.* § 102.66(d). The status of an acute-care hospital is an issue that the Employer must raise in its Statement of Position. *See* GC Memo 15-06, at p. 18 (Issues to be Litigated in a Pre-Election Hearing). As explained above, the Union petitioned for all registered nurses at the Employer's "Acute Care Hospital," and the Employer did not contest this as an issue. Nor did the Employer request to amend its Statement of Position to include the issue of the status of acute-care hospital. Accordingly, the appropriate unit under the Health Care Rule is for all registered nurses employed by Employer at its acute-care hospital located at 509/428 Biltmore Ave.

Even if the status of acute-care hospital were in issue, which it is not, the record evidence shows that 509/428 Biltmore Ave. constitute the Employer's acute-care hospital. The NLRB defines acute-care hospital as "either a short term care hospital in which the average length of patient stay is less than thirty days, or a short term care hospital in which over 50% of all patients are admitted to units where the average length of patient stay is less than thirty days." 29 C.F.R. § 103.30(f)(2).

[4] As will be set forth below, it is in fact an integrated single-facility, acute-care hospital with one emergency department and an overlapping license that covers both 509 and 428 Biltmore.

"[T]he main hospital is what we refer to as Mission Hospital or Mission Memorial and St. Joseph's located in Asheville, North Carolina, which is in Buncombe County." Tr. Vol. 2, at p. 39. Except for the Long-Term Acute Care Hospital ("LTACH") located on the fourth floor of 428 Biltmore, Mission Main (509 Biltmore) and St. Joseph (428 Biltmore) operate under the same Hospital license. Pet'r Ex. 17. The license for Mission Hospital has licensed beds at the "St. Joseph campus." *Id.*; Tr. Vol. 2, at p. 53 ("[St. Joseph's is] where our 82 life and behavioral beds are located."). 509 Biltmore Ave. is across the street from 428 Biltmore, and the two addresses are not even a block apart from each other. Emp'r Ex. 7.

What is more, a part of Mission Main's Emergency Department is located at the St. Joseph's Campus. The Psychiatric Evaluation Area ("PEA"), located at 428 Biltmore, is "part of the emergency department" of Mission Main at 509 Biltmore. Tr. Vol. 7, at p. 807. For instance, a patient will first go to the emergency room at Mission Main, where an emergency room physician will see the patient. *Id.* at 806. The patient is then transported the short distance to 428 Biltmore, *see* Emp'r Ex. 7, where the patient undergoes further evaluation per emergency department procedures, Tr. Vol. 7, at p. 808. The patient is then discharged or admitted into inpatient care either to a behavioral health bed at 428 Biltmore or to other facilities, per emergency department procedures. *Id.* On the average day, twenty-three (23) patients come from Mission Main Emergency Department to the Emergency Department at the PEA. *Id.* at 809. The RNs at the PEA have a supervisory structure that runs through the Director Behavioral Health Services, Melina Arrowood, which ultimately runs to the Chief Nursing Officer, Karen Olson. *Id.* at 810; Emp'r Ex. 1, at p. 3. The average length of stay for patients admitted to an inpatient behavioral-health bed at 428 Biltmore is less than one week. Tr. Vol 7, at p. 810. Not only is 428 Biltmore an extension of Emergency Department at 509 Biltmore, the average length of stay of patients squarely falls within the definition of "acute care hospital" under the Health Care Rule.

In addition to the PEA and the Behavioral Health Units, 428 Biltmore contains LTACH, which is a long-term acute-care hospital. LTACH, also referred to as Asheville Specialty Hospital or ASH, is owned and operated by MH Asheville Specialty Hospital, LLC. Pet'r Ex. 16. It has 34 licensed "general acute" care beds at 428 Biltmore with an average length of patient stay of 25 days. *Id.*; Emp'r Ex. 18, at p. 1; Tr. Vol. 5, at p. 533 (testimony of Julie Dikos). Under the Health Care Rule, the LTACH portion of 428 Biltmore also qualifies as an acute-care hospital. As such, 509/428 Biltmore constitute the acute-care hospital of the Employer.[5]

2. The Employer Cannot Show "Extraordinary Circumstances" to Overcome the Patently Appropriate Unit at the Acute-Care Hospital.

The Employer cannot show "extraordinary circumstances" to overcome the Health Care Rule's finding that a unit of all registered nurses at "acute care hospitals" is an appropriate unit. The Board will not apply the Health Care Rule to acute-care hospitals only when there are "extraordinary circumstances" or there is an existing non-conforming unit.[6] 29 C.F.R. § 103.30. The "extraordinary circumstances" exception to the Health Care Rule is extraordinarily narrow, and the party urging extraordinary circumstances bears a "heavy burden." *Id.*; *Boston Med. Ctr. Corp.*, 330 NLRB 152, 167 n. 35 (1999); *The Child's Hosp.*, 307 NLRB 90, 92 (1992); *St. Margaret Mem'l Hosp.*, 303 NLRB 923, 923 (1991); 53 Fed. Reg. 33900 (1988). To prove "extraordinary circumstances," the employer must show its argument is "substantially different" from those arguments the Board considered during the rulemaking process that "there are such unusual and unforeseen deviations from the range of circumstances already considered that it would be 'unjust' or 'abuse of discretion' for the Board to apply the [Health Care] Rule to the

[5] Although the Union does not believe the Employer established a single employer, should the Acting Regional Director find otherwise, the Union as set forth on the record would seek to represent all RNs of the single employer at the acute-care hospital located at 509/428 Biltmore.

[6] It is undisputed that there is no existing non-conforming unit at Mission Hospital.

facility involved." *St. Margaret*, 303 NLRB at 923.

In promulgating the Health Care Rule, the Board announced a non-exhaustive list of examples that would not constitute an "extraordinary circumstance":

> (1) Diversity of the industry, such as **the sizes of various institutions, the variety of services offered by individual institutions, including the range of outpatient services** provided, and differing staffing patterns among facilities (as, for example, a particular facility employing a larger or smaller number of RNs than generally employed by similarly situated hospitals); (2) **increased functional integration** of, and a higher degree of work contacts between, employees as a result of the advent of the multi-competent worker, increased use of "team" care, and cross-training of employees; (3) **the impact of nation-wide hospital "chains"**; (4) recent changes within traditional employee groupings and professions, e.g., the increase in specialization among RNs; (5) the effects of various governmental and private cost-containment measures; and (6) **single institutions occupying more than one contiguous building.**

53 Fed. Reg. 33933 (emphasis added). Strong community of interest with other groups of employees is not an extraordinary circumstance to overcome the Health Care Rule. *St. Margaret*, 303 NLRB at 924 ("[F]unctions and skill levels; education, licensing and training; wages, hours and working conditions; and interaction with other employees were matters raised in the course of the rulemaking proceeding and were among the factors extensively considered and analyzed by the Board . . . .") (finding no extraordinary circumstance because of alleged strong community of interest between skilled maintenance employees and other nonprofessional employees).

The Employer raises no argument that the Board failed to consider when promulgating the Health Care Rule. The crux of the Employer's argument is that the petitioned-for nurses share a community of interests with nurses across its wide healthcare system that provides various services at different locations. These are all arguments that the Board considered and rejected at rulemaking. Even if the Employer proved that the petitioned-for nurses held a strong community

of interest with the RNs at the Employer's outlying clinics, this would not be an "extraordinary circumstance." *See St. Margaret*, 303 NLRB at 924. Ultimately, the Union petitioned for RNs at the acute-care hospital, which the Health Care Rule makes an appropriate unit. The fact that the Mission acute-care hospital belongs to a larger healthcare system that provides other services does not render it inappropriate. As such, the Employer has failed to prove extraordinary circumstances.

There is seldom a case to which the Employer can point to show extraordinary circumstances. *Child's Hospital* ("*Child's*") is the rare instance where the Board found "extraordinary circumstances" as to overcome the Health Care Rule, which is inapposite to the case at bar. *The Child's Hosp., Samaritan Serv. Corp. (Child's)*, 307 NLRB 90 (1992). In *Child's* the Board faced a unique healthcare facility, which was not the type of facility that the Board considered in promulgating the Health Care Rule. The facility at issue contained three separately incorporated entities that provided different services: the hospital that provided inpatient and ambulatory services, a nursing home, and a corporation that serviced both. *Id.* at 90. All of these services were physically joined in one contiguous building. The hospital predominantly performed outpatient ambulatory care; "outpatient ambulatory surgery constitute[d] approximately 95 percent of the medical services." *Id.* at 91. The Board found "extraordinary circumstances" and did not apply the Health Care Rule because there was "physical joinder of the nursing home and the hospital" both of which made up "substantial" parts of the facility's operations. *Id.* at 92. The facility in *Child's* was a "hybrid facility" that did not fit "within a rule that is designed to cover the more typical *free-standing acute care hospital*." *Id.* As such, the Board in this rare instance found extraordinary circumstances and did not apply the Health Care Rule.

Unlike *Child's*, the petitioned-for unit in the instant matter is for the "free standing acute care hospital" of Mission Hospital located at 509/428 Biltmore. While there is a larger medical

campus comprised of separate medical buildings, the acute-care hospital is freestanding and predominantly provides inpatient, acute-care services. The ambulatory services that Mission provides "are outside of the main four walls of the main acute care campus." Tr. Vol. 2, at p. 54:15–16 (testimony of Joseph Rudisill). What is more, the ambulatory services that Mission provides—all outside of the acute-care hospital—constitute a minority of its services. There are approximately 1,826 registered nurses that work at the acute-care hospital.[7] There are only 582 nurses that work outside of the acute-care hospital in the ambulatory setting. The acute-care services are the predominant services that Mission provides. This is not a "hybrid" facility where acute care is a distinct minority of services as in *Child's*. As such, the petitioned-for unit is for a typical free-standing acute-care hospital, and the Employer cannot show "extraordinary circumstances" to overcome this patently appropriate unit.

Other Regions' application of *Child's* compels a finding that the Employer failed to prove extraordinary circumstances. *Pleasant Valley Hosp.*, Decision and Direction of Election, NLRB Case No. 09-RC-244587 (Aug. 8, 2019). Region 9 applied *Child's* in *Pleasant Valley* to find that under the Health Care Rule the union's petition for RNs at the acute-care hospital was an appropriate unit, and the Employer's healthcare system was not an "extraordinary circumstance" because it failed to show sufficient physical joinder and the substantial nature of operations between the acute and nonacute facilities were distinct. *Id.* at 8–9.[8]

There is no physical joinder of the facilities to support a finding of extraordinary circumstances. In *Pleasant Valley*, the employer argued that a petition for all RNs at its acute-care

[7] This figure is based on the numbers from Employer's Attachment B as well as the number of nurses that work at the LTACH.

[8] The Union is of the view that the Regional Director need not apply *Child's* to find that the Employer failed to prove extraordinary circumstances. The fact that the Board rejected the same type of arguments during rulemaking that the Employer makes here should end the inquiry.

hospital was inappropriate because it failed to include 14 nonacute clinics, including a Medical Office Building that was attached to the acute-care hospital. *Id.* at 3. Many of the clinics were "as close as 'across the street' or on the same campus as the hospital." *Id.* at 9. Relying on *Child's*, Region 9 nevertheless found that the employer failed to prove sufficient physical joinder, which precluded extraordinary circumstances. *Id.* (citing *Child's*, 307 NLRB at 90 n. 7) (noting that the *Child's* Board relied on the contiguous physical facility and considered "[n]o other outlying facilities or buildings" even though there were two other facilities on the medical campus in *Child's*). As in *Pleasant Valley*, none of the nonacute buildings are physically joined to create one, physically contiguous structure. Only the nonacute building of 1 Hospital Drive has a walkway that connects to 428 Biltmore. Like in *Pleasant Valley*, this attachment is not sufficient to prove the necessary physical joinder. Similarly, there is no extraordinary circumstance despite nonacute buildings located on the same medical campus as the petitioned for acute-care hospital. The lack of physical joinder with the acute-care hospital precludes extraordinary circumstances.

Region 9 also found that an "extraordinary circumstances" finding was precluded in *Pleasant Valley* because the "substantial nature of the operations" of the clinics. While there were some commonalities, such as common HR department and policies and the use of an electronic medical record system, the nature of operations were distinct between the acute and nonacute facilities. *Id.* at 9. Additionally, the nurses had distinct supervisors, there was no required floating, and the record only showed a small amount of interchange between the acute and nonacute facilities. Just as in *Pleasant Valley*, the nature of the operations is distinct between the acute and nonacute facilities, as further explained below. What is more, the acute and nonacute facilities each have their own distinct supervisors, all floating is on a voluntary basis, and the Employer has only shown very small amount of interchange considering that it proposes the unit should include approximately 2,400 employees. Because the nature of the operations is

substantially distinct between the acute and nonacute facilities, there are no extraordinary circumstances, and the petitioned-for unit of all RNs at the acute-care hospital is appropriate.

B. A Unit of Registered Nurses at the Acute-Care Hospital Is Appropriate Regardless of the Single-Facility Presumption, Which Applies to the Instant Petition.

The petitioned-for unit is appropriate under the single-facility presumption, which the Employer failed to call into question through its Statement of Position. Even if the single-facility presumption did not apply, exclusion of the nonacute facilities is not arbitrary because the Health Care Rule requires acute-care facilities alone. The Employer failed to establish a uniformity of community of interest with the petitioned-for acute care RNs.

1. The Single-Facility Presumption Applies to Mission's Acute-Care Hospital at 509/428 Biltmore Ave.

Under the single-facility presumption, the petitioned-for unit of all registered nurses at the acute-care hospital at 509/428 Biltmore is presumptively appropriate. The Board has long held that the single-facility presumption applies in the healthcare industry, including to acute-care hospitals under the Health Care Rule. *Catholic Healthcare West*, 344 NLRB 790, 790 (2005); *see also St. Luke's Health System, Inc.*, 340 NLRB 1171, 1172 (2003), *Visiting Nurses Ass'n of Central Ill.*, 324 NLRB 55 (1997); *Children's Hosp. of San Francisco*, 312 NLRB 920 (1993). To overcome the single-facility presumption, the Employer has, again, a "heavy burden" to show "integration so substantial as to negate the separate identity of the single facility." *Catholic Healthcare West*, 344 NLRB at 790 (citing *Heritage Park Health Care Ctr.*, 324 NLRB 447, 451 (1997), *enfd.* 159 F.3d 1346 (2d Cir. 1998)).

In the present case, the Union petitioned for a single facility of the Employer's acute-care

Hospital. Bd. Ex. 1(a) (question 4a (Type of Establishment)) ("Acute Care Hospital").[9] The Union's petition put the Employer on notice that it was seeking a single-facility acute-care hospital. Nevertheless, the Employer did not dispute that the Union's petition was for a single facility in its Statement of Position; it merely claimed that the petition failed to include registered nurses employed by other employers in its "integrated enterprise" and RNs with whom the registered nurses in the petitioned-for unit share a community of interest. Bd. Ex. 3. As explained above, Board Regulations require the Employer to state all issues in its timely Statement of Position. 29 C.F.R. §§ 102.63(b)(1)(i) & 102.66(d). Because the Employer did not raise an issue as to whether the petition was for a single facility, the single-facility presumption applies, and the Employer waived any argument that it does not.

What is more, the acute-care hospital located at 509/428 Biltmore is the only facility that provides acute-care, inpatient services when considering the additional locations that the Employer seeks to add to the unit. As explained further below, under the Health Care Rule, appropriate units are for those facilities that primarily provide *acute care*. It is undisputed that the outpatient surgery and clinical locations the Employer seeks to add provide only *nonacute* healthcare services, which have a totally separate identity from the services the Employer provides at the acute-care hospital. Given that the acute-care hospital retains a distinct identity from the Employer's proposed additional nonacute locations, the petitioned-for unit is presumptively appropriate.

[9] In its description of Unit involved (Question 5), the Union described it as "All [RNs], employed by the employer at its *facility* located at 509 Biltmore Ave., Asheville, NC 28801 and 428 Biltmore Ave., Asheville, NC 28801." Bd. Ex. 1(a) (Attachment A) (emphasis added).

2. Even If the Single-Facility Presumption Is Not Applicable, Exclusion of the Nonacute Facilities Is Not Arbitrary Because the Health Care Rule Requires Acute-Care Facilities Alone.

Regardless of whether the single-facility presumption applies to the instant matter, which it most surely does, again the acute-care hospital at 509/428 Biltmore is the only location that the Act requires to be included in the unit. A unit need not include nonacute-care facilities when a union petitions for acute-care facilities and for those facilities alone. *See* 29 C.F.R. 103.30; 53 Fed. Reg. 33904 ("Recognizing the diversity of facilities other than acute care hospitals and nursing homes . . . . [t]hese other health care facilities continue to be excluded from coverage."); 53 Fed. Reg. 33931 ("Coverage for the purpose of [the Health Care Rule] . . . will include all acute care hospitals as defined. A hospital is covered if its *primary* service is acute care, regardless of the presence of other non-acute care units at the *same* facility." (emphasis added)). Because the Union petitioned for the *only* facility that has a "primary service [of] acute care," it is clearly an appropriate unit under the Health Care Rule and it need not include the Employer's other locations that primarily provide nonacute care.

The Board has never held that a unit must include a healthcare network's various nonacute clinics when a union petitions for the network's acute-care hospitals alone. In fact, an analysis of the relevant Board precedential law shows that the Health Care Rule does not extend beyond acute-care facilities. *Pleasant Valley Hosp., LLC*, Decision and Direction of Election, NLRB Case No. 09-RC-244587 (Aug. 8, 2019) (finding that under the Health Care Rule, a unit need not include nonacute clinics and nursing and rehabilitation center when union petitions only for the acute-care facility); *Prime Healthcare Servs.*, Decision on Remand and Direction of Election, NLRB Case No. 32-RC-156669, at p. 5 n. 3 (Aug. 9, 2016) ("I note that if the Rule were found to be applicable to entire healthcare systems which include acute care hospitals, it would in some cases result in very large bargaining units that span extensive geographic areas.

Furthermore, a finding that the Rule applied to entire healthcare systems would lead, in many situations, to units which include numerous non-acute healthcare facilities.").

In *Prime Healthcare*, the Region 32 Regional Director analyzed various Board decisions to conclude that nonacute-care facilities should not be subject to the Health Care Rule's requirements unless the nonacute and acute-care facilities are "properly treated as a combined, single facility." *Prime Healthcare Servs.*, *supra*, at pp. 4–5 (citing *Virtua Health Inc.*, 344 NLRB 604 (2005); *Stormont-Vail*, 340 NLRB 1205 (2003); *Visiting Nurses Ass'n of Central Ill.*, 324 NLRB 55 (1997)). The Employer did not raise in its Statement of Position—or argue at hearing—that the various medical buildings in Employer Exhibit 7 constituted a single-facility, acute-care hospital. Rather, it concedes that the acute-care hospital is only located at 509/428 Biltmore but argues that the unit should include registered nurses at its nonacute-care buildings, including 22 buildings that span a 10-mile distance from the acute-care hospital based on a shared community of interest. Because the Employer has failed to raise that any of its other 22 buildings should be "properly treated as a combined, single facility," it would be in error for the Acting Regional Director to direct the inclusion of these locations into a unit solely comprised of the acute-care-hospital RNs.

In *Virua Health, Inc.*, the Board declined the Employer's invitation to apply the Health Care Rule to a systemwide unit. There, the union petitioned for a unit of paramedics excluding other technical workers at the employer's systemwide acute and nonacute facilities. 344 NLRB at 604–05. Under the Health Care Rule, "A unit of paramedics who constitute only a portion of the employer's technical employees at an *acute-care hospital* would be inappropriate." *Id.* at 605 (emphasis added). The regional director found the Health Care Rule inapplicable and that a systemwide unit of only paramedics was appropriate. *Id.* at 604. On review, the Board found it unnecessary to apply the Health Care Rule but ruled that the unit was inappropriate under the

community-of-interest standard for nonacute facilities as set forth in *Park Manor Care Center*, 305 NLRB 872 (1991). *Id.* at 605. When presented with an opportunity to apply the Health Care Rule to systemwide units that include both acute and nonacute facilities, the Board has avoided application.

The Board again avoided applying the Health Care Rule when a union sought a unit of both acute and nonacute facilities in *Stormont-Vail Healthcare*. *In re Stormont-Vail Healthcare, Inc.*, 340 NLRB 1205 (2003). In that case, the union had originally petitioned to represent RNs at the acute-care hospital complex; however, it then stipulated to include nurses in a separate nonacute facility[10] as well as helicopter RNs based outside the hospital at three separate nonacute locations. *Id.* at 1206–07. By agreeing to include nonacute-care locations into the unit, the union took its unit outside the ambit of the Health Care Rule, and the petitioned-for unit was no longer presumptively appropriate. *Id.* Unlike *Stormont-Vail*, the petitioned-for unit in the case at bar is only for the acute-care hospital of 509/428 Biltmore; the petitioned-for unit does not include any of the Employer's nonacute buildings or RNs based at nonacute locations. Because the petitioned-for unit is for the acute-care hospital alone, it squarely falls within the Health Care Rule, and the unit is appropriate.

The Health Care Rule does not extend to petitioned-for nonacute facilities even when they are part of a broader healthcare system that includes close-by acute facilities. In *Visiting Nurses*, the employer argued that the union's petition for registered nurses at a nonacute facility ("VNA") was inappropriate under the Health Care Rule because it failed to include registered nurses at its acute-care hospital ("MMC") two-and-a-half blocks away. 324 NLRB at 55. The Board

[10] The parties in *Stormont-Vail* failed to stipulate that this separate nonacute care facility, which was connected by a walkway to the acute-care buildings was part of a "single facility with the hospital complex." 340 NLRB at 1207 n. 9.

acknowledged that there were factors that weighed in favor of finding a multifacility unit with MMC, such as common personnel department, close geographic proximity, substantial percentage of permanent transfers, and shared nonmedical services. *Id.* at 56. However, the Board also noted that VNA retained control of daily labor relations and there was only minimal interchange and contact between the two facilities. *Id.* For instance, VNA had its own supervisors and had control over hiring and firing, and floating only occurred on a voluntary basis, with only "25 of over 500 RNs hav[ing] 'floated' from MMC to [VNA] over a 1-year period." *Id.* Ultimately, the Board rejected the employer's attempt to shoe horn a nonacute facility into a "hospitalwide" unit under the Health Care Rule because "the petitioned-for single [nonacute] facility retains its separate identity. MMC is an acute care hospital. [VNA]'s services—home health and hospice care—are distinct from those provided by MMC." *Id.* at 55.

In the instant matter, the Employer has an even heavier burden to prove that a petitioned-for acute-care hospital is inappropriate because it fails to include separate nonacute facilities. As detailed above, when a union petitions for all RNs at acute-care hospitals, the unit is patently appropriate absent extraordinary circumstances. While the Employer may have introduced some evidence favoring a multifacility unit, such as close geographic proximity, common personnel policies, shared nonmedical services, and "some degree of functional integration," this is insufficient to vitiate the Health Care Rule. And under *Visiting Nurses*, the Employer's evidence is insufficient to foist nonacute facilities onto a unit composed solely of RNs at the acute-care hospital. As in *Visiting Nurses*, while the central HR may have input and sign-off on personnel decisions, the local hiring managers retain ultimate control over hiring, discipline, and discharging

employees. The nonacute facilities have their own supervisors.[11] Additionally, there is only minimal contact between the acute-care hospital and the nonacute facilities, and floating is all voluntary and minimal. The Employer failed to introduce reliable evidence as to the frequency of floating; the only non-conclusory evidence of floating between facilities is from Employer Exhibit 16,[12] which shows fourteen (14) RNs—out of 2,400 RNs in the Employer's proposed unit—floating between the various facilities over a two-year period. The minimal interchange is starker here than in *Visiting Nurses*. Most importantly under the *Visiting Nurses* analysis, the petitioned-for acute-care hospital at 509/428 Biltmore retains a separate identity from the nonacute facilities that the Employer seeks to add. None of these facilities provides acute-care services and, as such, they are distinct from the services provided by the acute-care hospital.

Board law is clear that a petition for all RNs at acute-care hospitals constitutes an appropriate unit. As Regional Directors have found, Board precedent does not find such a unit to be inappropriate because it fails to include nonacute facilities that are within the Employer's broader healthcare system. Accordingly, the Union's petitioned-for unit is not only appropriate, a unit of the 509/428 Biltmore acute care RNs is the only unit required under the Health Care Rule, absent extraordinary circumstances, again, which are not present, and is an argument the Employer waived.

[11] The only example of common supervision between the inpatient and outpatient is Wound Care nurses. There are only five inpatient Wound Care nurses and no interchange because outpatient Wound Care nurses lack the certification to perform inpatient duties.

[12] Employer Exhibit 16 is the only example of evidence that the Employer proffered that shows any degree of frequency of interchange. Rather, the Employer primarily relies upon conclusory statements that are inappropriate for it to meet its heavy burdens.

3. The Employer Failed to Prove a Uniformity of Community of Interest With the Petitioned-for Acute-Care RNs.

The Employer has sought to present evidence that a particularly defined bargaining-unit is the only appropriate bargaining unit in these circumstances. The defining feature of that unit is the Buncombe County line. The Employer argues that although the Union has petitioned for a patently appropriate unit of all Registered Nurses at an acute-care hospital, the exclusion of other registered nurses and advanced practice registered nurses is arbitrary because there is no community of interest sufficiently distinct from those nurses at the outlying nonacute facilities. This argument fails for four reasons. First, as noted several times above, the appropriateness of the petitioned for unit is statutorily defined in the Board's Health Care Rule. *See* 54 Fed. Reg. 16336-16348 (1989). When the Board overturned *Specialty Healthcare & Rehabilitation Center of Mobile*, 357 NLRB 934 (2011) in *PCC Structurals Inc.*, it specifically stated that it was returning to the standard set forth in *Park Manor Care Center, supra*, for determining appropriate bargaining units in nonacute healthcare facilities. 365 NLRB No. 160, n. 3 (2017). Then-Chairman Miscamarra remarks that in returning to the *Park Manor* standard, acute-care facilities remain governed by the Board's 1989 Health Care Rule. *Id.* at n. 24.

Second, the Employer's evidence has failed to establish a uniformity of community of interest among some of the most prominent outlying, nonacute facilities they seek to include with the acute-care RNs at the 509/428 Biltmore acute-care hospital to the point where any discussion of arbitrariness widely misses the mark. For example, the RNs at the Ashville Surgery Center have a distinct supervisory structure until the highest levels of upper system management, Tr. Vol. 7, at pp. 767, 849–50, they have a separate sterile processing department, Tr. Vol. 7, at p. 774, there is very limited interchange between nurses at ASC and the main hospital at 509/428 Biltmore, Tr. Vol. 7, at pp. 767–78, 852–23. But for conclusory testimony, such as "we actually, in the past,

have had nurses come over and will pick up extra shifts in our clinic if we are short staffed," Tr. Vol. 5, at pp. 468–89 (clinical nurses at 21 Hospital Drive), the Employer established no regular interchange or interface between clinic nurses and the acute-care RNs at the 509/428 Biltmore acute care hospital. For example, asserted interchange by "filling in" for 509/428 Biltmore acute care hospital nurses was sporadic at best, such as if "really . . . short staff[ed]" and a clinical RN wanted an extra shift, Tr. Vol. 3 at pp. 300–01 (clinical nurses at 5 Vanderbilt Park Drive). Likewise, the Employer could only come up with a handful of nurses who may float between clinic locations and the 509/428 Biltmore acute care hospital and on a very infrequent basis. Tr. Vol. 9 at pp.1036–52. And the Employer's self-described "internal staffing agency" to fill staffing "holes" in the Rehabilitation Hospital says nothing about the community of interest between outpatient clinic nurses and the 509/428 Biltmore acute care hospital RNs. Tr. Vo. 10, at p. 1279.

Third, the Employer put on extensive testimony about the functional integration of the outlying, nonacute facilities with the acute-care hospital at 509/428 Biltmore, much of it conclusory, demonstrative, and cumulative. However, the Employer here proved too much. Much of its evidence for functional integration, organizational structure, terms and conditions of employment, and common control demonstrates that a system-wide unit limited only to Buncombe County, as the employer here seeks, would itself be arbitrary because the integration, management, and control is functionally region or statewide. To name but only a few examples, the recruiting for positions within the system is done on a statewide basis, Tr. Vol 2, p. 117; the on-boarding of new hires is done on a statewide basis, Tr. Vol. 3, p. 150; HR system LAWSON is North Carolina division wide, Tr. Vol. 2, p. 126; the benefits package offered to employees is North Carolina division wide, Tr. Vol. 2, p. 131; payroll and HR functions are centralized for the entire state, Tr. Vol. 3, pp. 154, 182–85; the policy online "handbook" is North Carolina division wide, Tr. Vol. 3, p. 159; the in-house employee health and wellness service WorkWell is North

Carolina division wide, Tr. Vol. 3, p. 170; Physicians Services Group has its own HR Vice President that reports directly to HCA, Tr. Vol 3, p. 184; Physicians Services Group VP and CarePartners VP report directly to HCA North Carolina division chief Greg Lowe, Tr. Vol. 8, pp. 923–24; not all of the Employer's labs that are run from Mission Health are even in Buncombe County, Tr. Vol. 8, p. 927. On the basis of the Employer's record evidence, not only has it failed to demonstrate a community of interest between the nurses at the outlying, non-acute facilities so closely held as to not be distinct from those at the acute-care hospital, it has also failed to show why that community of interest would stop at the Buncombe County line and not extend to HCA's entire North Carolina division. As noted above, Regional Directors have roundly rejected such arguments. It would be in error to direct an election for a non-conforming, multi-facility unit. While it may be true that there potentially exists a community of interest between the registered nurses at a select number of the Employer's outlying, nonacute facilities, the appropriate course of action should they ever seek union representation by inclusion in a bargaining unit of RNs at the acute-care hospital is a subsequent *Armour-Globe* self-determination election. Requiring their inclusion at this time, again, would be in error, contrary to the Health Care Rule.

Finally, as has been stated above but cannot be stressed enough, the Employer must show "extraordinary circumstances" to overcome the Health Care Rule's finding that a unit of all registered nurses at "acute care hospitals" is the appropriate unit. Community of interest, even strong community of interest, with other groups of employees outside the acute-care hospital setting does not rise to the level of "extraordinary circumstances." *St. Margaret*, supra. at 924. The Employer is asking the Region to take a radical departure from Board law and apply the *Park Manor* standard for community of interest that applies to nonacute healthcare facilities rather than the codified Health Care Rule. However, even under the test set forth in *Park Manor* the Employer comes up wanting. In short, the unit sought by the Employer has no basis in Board law and itself

can only be characterized as an arbitrary grouping no more distinct in its community of interest from numerous larger or smaller groups of nurses working for HCA in North Carolina. The Union's petitioned-for unit remains appropriate and distinct under the Health Care Rule.

C. The Appropriate Unit Is RNs Employed by MH Hospital Manager, LLC at the Acute-Care Hospital; Even If the Region Finds an "Integrated Enterprise" Single Employer, CRNAs and NPs Do Not Share a Community of Interest with the Bedside RNs

The Employer has failed to prove that it with two other employer entities are a single-integrated employer necessitating the inclusion of those employees into the unit. Even if the Region finds that the Employer has met this difficult burden, inclusion of CRNAs and NPs, employed by MHCMP, is inappropriate.

1. MH Hospital Manager, LLC Is Not a Single Employer with MH Community Multispecialty Providers, LLC and MH Asheville Specialty Hospital, LLC

The Employer, MHHM, failed to prove that it is an integrated enterprise with MHCMP and MHASH as to constitute a single employer. To prove that multiple separate employing entities constitute a single employer, the Employer must prove "common ownership, common management, interrelations of operations, and common control of labor relations." *Mercy General Health Partners Amicare Homecare*, 331 NLRB 783, 784 (2000) ("*Amicare*") (citing *Radio Techs Local 1264 v. Broad. Serv. of Mobile*, 380 U.S. 255, 256 (1965); *Denart Coal Co.*, 315 NLRB 850, 851 (1994)). While no one factor is determinative, the Board places special emphasis on the centralized control over labor relations. *Id.* (citing *W. Union*, 224 NLRB 274, 276 (1976)).

The Record lacks evidence showing common ownership and common management. In parent-subsidiary relationships, common ownership is insufficient. Rather, a "single employer relationship will be found only if one of the companies exercises actual or active control over the

day-to-day operations or labor relations of the other." *Id.* at 784–85. Also relevant to this inquiry are the levels of separate ownership. *Id.* at 785. It is undisputed that HCA, the country's largest for-profit hospital chain bought the Mission Health entities in or about 2019. However, the Employer failed to introduce sufficient evidence to satisfy these prongs of the single-employer test, namely failing to prove that any of the employer entities exercise control over the others.

In terms of common ownership, the Employer only introduced unreliable evidence that should not be given weight. According to the Employer's self-serving demonstrative Exhibit No. 5, MH Hospital Holdings, Inc. owns both MHASH and MHHM. MHCMP, on the other hand, is separated by several levels of ownership from MHASH and MHHM.[13]

As for common management, while there is some evidence that HCA exercises control over the employer entities as it does with the other facilities it owns, there is no evidence that MH Hospital Holdings, Inc. exercises control over MHHM, MHCMP, or MHASH; nor does the record show that MHHM, MHCMP, or MHASH exercise any control over each other. The Employer's evidence is totally unreliable. Employer Exhibit No. 1 and the Employer's testimony evidence show that Greg Lowe is the CEO of HCA North Carolina Division. Tr. Vol. 2, at p. 38. However, it is unclear what legal entity the HCA North Carolina Division is.[14] The Union requested documents through subpoenas *duces tecum* showing ownership of the employer entities

[13] MH Hospital Holdings, Inc. (99% of shares) and MHHM (1% of shares) own MH Master Holding LLLP. MH Master Holding LLLP (99% of shares) and MH Master LLC (1% of shares) own CarePartners Rehabilitation Hospital, LLLP CarePartners Rehab Hospital, which owns MHCMP.

[14] Joseph Rudisill described the HCA North Carolina Division as "a number of different corporate entities" with MH Hospital Holdings, Inc. as being "the top entity for purposes of Mission Health or the North Carolina Division." Tr. Vol. 2, at p. 46. It can only be assumed that Lowe is the CEO of MH Hospital Holdings, Inc. But there is no evidence directly making this connection. The Employer's sole reliance on cursory evidence and conclusory testimony from leading questions to make its case for single employer is insufficient to meet its burden.

and their Board of Directors, Members, and Corporate Officers. Pet'r Exs. 2–4 (Requests Nos. 1 & 3). The documents the Employer provided, Employer Exhibits 1 and 5, do not show this information. The Employer claimed it had no further responsive documents.[15]

Moreover, the Record does not show that any of the entities exercise any actual or active control over the day-to-day operations. It merely shows that the leaders of MHHM and MHCMP attend regular meetings. Additionally, each entity has its own managers and supervisors. Chad Patrick manages MHHM, Mickey Pickler manages MHCMP, and Julie Dikos manages MHASH. There is no evidence of cross management between these organizations. Rather, each employer entity has its own, separate management.

For interrelations of operations, the Board looks to factors such as "sharing of facilities, equipment, and personnel." *Dodge of Naperville, Inc.*, 357 NLRB 2252, 2269 (2012) (citing *Emsing's Supermarket*, 284 NLRB 302, 304 (1987)). Leasing of facilities and employees wearing the same common logo are insufficient to support a conclusion that the entities are functionally integrated. *Amicare*, 331 NLRB at 785. In totality, the Employer is unable to establish that MHHM, MHCMP, and MHASH have interrelations of operations as to be functionally integrated. While MHHM, MHCMP, and MHASH are all located at the acute-care hospital, the Employer failed to prove that this sharing of facilities was more than an arm's-length relationship, i.e., beyond leasing of space at the acute-care hospital. Additionally, MHCMP has ten facilities[16] that does not have MHHM or MHASH employees. Bd. Ex. 3. There is no

[15] It is unfathomable that the Employer has no responsive documents to Requests 1 and 3. For instance, Julie Dikos, CEO for MH Asheville Specialty Hospital, LLC, testified that she reports to Tracy Buchanan, the chair of the board. Tr. Vol. 5, at p. 532.

[16] 2695 Hendersonville Road, Arden, NC; 890 Hendersonville Road, Asheville, NC; 310 Long Shoals Road, Arden, NC; 2 Medical Park Drive, Asheville, NC; 14 Medical Park Drive, Asheville, NC; 63 Monticello Road, Weaverville, NC; 41 Oakland Road, Asheville, NC; 2100 Ridgefield

evidence in the record that the three entities share equipment. As for sharing of personnel, the Employer put on very limited evidence that RNs from MHCMP can voluntarily take a shift for which MHHM is the employing entity; however, when a MHCMP RN takes such a shift, the MHHM cost center is billed for the time worked at that MHHM department. Emp'r Ex. 16. This is not sharing of personnel; rather, this evidences an arm's-length relationship with separate billing for the distinct sets of employees.

The Employer is unable to establish the critical factor in the single-employer test: centralized control over labor relations. "[N]o single-employer relationship exists where the actual day-to-day management and labor relations functions are carried out by each entity's own managers and officers." *Amicare*, 331 NLRB at 785. In the instant matter, MHHM, MHASH, and MHCMP share some personnel policies; however, many policies do not overlap over the three entities. For instance, 53 of the HR policies that the Employer produced in response to the Union's subpoena do not apply to MHCMP. Union Ex. 5. [17]

Boulevard, Asheville, NC; 1388 Sand Hill Road, Candler, NC; 900 Hendersonville Road, Asheville, NC.

[17] The following HR policies do not apply to MHCMP: 1HR HR 0007_Leaves_of_Absence 2016 revised 4.2018 (retired 11.2019).pdf; 1HR HR 0007_Leaves_of_Absence 2016 to 4.2018 revision.pdf; 1HR HR 0029_Employment_Classifications_and_overtime_2016 August 2018.pdf; 1HR.ADM.0001 Students, Interns, Observers, Residents and Faculty Current Version.pdf; 1HR.ADM.0001 Students, Interns, Observers, Residents and Faculty Initial Policy.pdf; 1HR.ADM.0003 Contacts with External Agencies Initial Policy.pdf; 1HR.ADM.0003_Contacts_with_External_Agencies_08132018.pdf; 1HR.ADM.0005 Personal Communiaction Current.pdf ; 1HR.ADM.0005 Personal Communication Initial.pdf; 1HR.ADM.0006 Screening for Sanctions Current Version.pdf; 1HR.ADM.0007 Witnesses in Court. Mission Health Employees Testifying in Legal Cases Current Version.pdf; 1HR.ADM.0009 Controlled Substances.Alcohol Testing for CDL Drivers.pdf; 1HR.HR.0002 Staff Rights and Responsibilities 10.25.15 - 9.2018.pdf; 1HR.HR.0002 Staff Rights and Responsibilities Current.pdf; 1HR.HR.0002 Staff Rights and Responsibilities.pdf; 1HR.HR.0004 System Drivers Current.pdf; 1HR.HR.0006 Primary Source Verification 1.2017-5.2018.pdf;

Additionally, while there may be a centralized HR department that handles applicant screens, background checks, and advises hiring managers on discipline, each employer entity has its own supervisors and managers, and there is no cross-supervision over the day-to-day operations between them. For instance, the RNs employed by MHHM have a chain of command that runs from the Nursing Unit Supervisor, Nursing Manager, Director, and ultimately leading to the Chief Nursing Officer, Karen Olson. Pet'r Exs. 6 (Job Description Registered Nurse – Surgery) ("Reports to: Nursing Management") & 8 (Job Description Registered Nurse) (same);

1HR.HR.0006 Primary Source Verification Current.pdf; 1HR.HR.0008 Education and Compliance 9.30.16 - 5.2018.pdf;1HR.HR.0008 Education and Compliance Current.pdf; 1HR.HR.0009 Reduction in Force 9.2016 - 9.2018.pdf; 1HR.HR.0009 Reduction in Force 9.2018.pdf; 1HR.HR.0009_Reduction_in_Force_12192018 current.pdf;1HR.HR.0011 Harassment.Discrimination.Retaliation 9.2016-3.2018 Version.pdf; 1HR.HR.0011 Harassment.Discrimination.Retaliation Current.pdf; 1HR.HR.0012 Employment of Relatives and Minors Current Version.pdf; 1HR.HR.0020 Bereavement Leave Current.pdf; 1HR.HR.0021 Terminations and Exit Interveiws Initial policy (1).pdf; 1HR.HR.0022_Emergancy_Loan_and_Grant 122914 review 2016 (retired 2019).pdf; 1HR.HR.0025 Orientation for New Team Members Current (2).pdf; 1HR.HR.0026 Talent Management - Performance and Engagement Current.pdf; 1HR.HR.0028_Rehire_Reinstatement_2018.pdf; 1HR.HR.0028_Rehire_Reinstatement_061215 - 4.2018.pdf; 1HR.HR.0038 Interim Compensation for Supervisory and Non-Supervisory Positions Current Version.pdf; 1HR.HR.0038 Interim Compensation for Supervisory and Non-Supervisory Positions Initial Policy.pdf; 1HR.HR.0041 Workers Compensation Program Currect Version.pdf; 1HR.HR.0041 Workers Compensation Program Initial Version.pdf; 1HR.HR.0043 Lactation.Nursing Employees Current (unchanged in 2018 from initial policy) (1).pdf; 1HR.HR.0045_Outside_Employment 061215 - 2018.pdf; 1HR.HR.0047 Employee Concern Process Current.pdf; 1HR.HR.0047 Employee Concern Process Initial Policy - 8.2018.pdf; 1HR.HR.0802 Holiday Hours of Operation.pdf; 1HR.HR.0803 10.2018 Version.pdf; 1HR.HR.0803 Premium Pay 3.18.2019 version.pdf; 1HR.VOL.0001 Volunteer Education and Competency Initial Version.pdf; 1HR.VOL.0001 Volunteer Education and Competency.pdf; 2HR.VOL.0002 Volunteer- Corrective Action Current.pdf; 2HR.VOL.0004 Volunteer Orientation Current.pdf; 2HR.VOL.0005 Harassment.Discrimination.Retaliation - Volunteers Current.pdf; 2HR.VOL.0005 Volunteer Service Descriptions Current.pdf; 2HR.VOL.0007 Volunteer Administration current.pdf; 91HR.HR.0001 CarePartners Premium Pay Policy original publication.pdf; maximum worked hours 6 30 16 (1).pdf

Tr. Vol 7, at p. 795 (testimony of Kelley Tyler, RN), at p. 810 (testimony of Kate McGee, RN), at p. 817 (testimony of Alison Gold, RN).

MHCMP employees, on the other hand, have a totally separate supervisory structure. The CRNAs report the CRNA Lead, the Associate Chief CRNA, the Chief CRNA, the Anesthesiologist, the Chief Anesthesiologist, and ultimately to the VP of MHCMP, Mickey Pickler. Pet'r Ex. 7; Tr. Vol. 7, at p. 763 (testimony of Andrew Hoaglan, RN); Tr. Vol. 10, at 1190 & 1206 (testimony of Douglas Roberts, CRNA). No one in the CRNA's supervisory chain supervises the RNs employed by MHHM or vice versa.

Nor is there cross supervision between the MHHM RNs and the Nurse Practitioners, which MHCMP employs.[18] NPs report to their Department's Practice Manager. Pet'r Ex. 9. The Practice Manager is the Medical Director for that Department. For instance, in the Neonatal Intensive Care Unit (NICU), the NPs report to the medical director for the neonatologists, Dr. Bender. Tr. Vol. 7, 829. NPs are in the same supervisory structure as the physicians and physician assistants. *Id.*; Emp'r Ex. 20, at 000426 (Job Description – Physician Assistant). NPs do not fall within the nursing supervisory structure; nor do RNs report to anyone in the NP's chain of command. Tr. Vol. 7, at pp. 829–30; Tr. Vol 8, at p. 875 (testimony of Nicole Baker, NP).

As for MHASH, the nurses employed there report to Joie Picker, the Director of Nursing at MHASH, and ultimately to the CEO of MHASH, Julie Dikos. Tr. Vol. 5, at p. 541. This supervisory structure is different than that of the RNs employed by MHHM; for instance, when an RN holds two positions, one at MHHM and one at MHASH, they have a separate supervisory

[18] MHCMP also employs three individuals in the classification of "Advanced Practitioner – ED Triage." Emp'r Ex. 4, at p. 11. This is a Nurse Practitioner position. Emp'r Ex. 20, at pp. 000626–29.

structure depending on where they are working on a given day. Tr. Vol. 5, at p. 551.

The record shows that each employer entity has its own supervisors and managers with no cross supervision over the other entities. Additionally, the leaders, such as hiring managers, for each entity maintain control over the personnel decisions, such as decisions to hire, fire, and discipline. Tr. Vol. 2, at pp. 121, 124, 126, 129, 132; Tr. Vol. 3, at pp. 176–77; Tr. Vol. 8, at p. 984. In its subpoenas *duces tecum*, the Union requested "Documents showing the participation of any other Employer in decision to hire . . . ." Pet'r Exs. 2 & 3 (Requests No. 10) & 4 (Request No. 11). The Employer claimed there was no responsive document showing cross control over such decisions. Tr. Vol. 6, at p. 728. Because the Employer failed to prove that the managers of the of the three employer entities—or even MH Masters Holdings, Inc. and HCA—exercise actual day-to-day control over labor relations functions, the Employer cannot establish that MHHM, MHCMP, and MHASH constitute a single integrated employer. Accordingly, a unit of the RNs employed by MHHM excluding employees of MHCMP and MHASH is appropriate.

2. Even If the Region Were To Find a Single Employer, CRNAs and NPs Are Properly Excluded

Even if the Region were to find that MHHM, MHCMP, and MHASH constitute a single employer, the CRNAs and NPs employed by MHCMP should be excluded from the unit of RNs.[19] CRNAs and NPs would more appropriately belong to a unit of other professionals. As detailed above, the Health Care Rule sets out eight units, which are the only appropriate units at acute-care hospitals, including a unit of "all registered nurses" and a unit of "all professionals except for registered nurses and physicians." 29 C.F.R. § 103.30(a)(1) & (3). In *Lee Hospital*,

[19] Although the Union does not agree that the Employer has proved that the three employer entities constitute a single employer, as stated on the record, the Union would proceed to an election if the Region finds single employer and includes CRNAs and NPs into the unit but only to the extent at the acute-care hospital of 509/428 Biltmore Ave.

the Board found that a unit of CRNAs at an acute-care facility "excluding all of the hospital's other professional employees" would be inappropriate. 300 NLRB 947, 947–48 (1990), *overturned on other grounds by M. B. Surgis, Inc.*, 331 NLRB 1298 (2000). Although the *Lee Hospital* Board did not discuss the different classifications of "professionals" with whom CRNAs share a community of interest, discussion of placing CRNAs with "other professionals" rather than with "registered nurses" suggests that the Board does not automatically place advanced practice RNs in a unit of "all registered nurses" simply because they have a registered nurses' license. *See id.* The Board issued its decision in *Lee Hospital* on December 21, 1990, nearly two years after it issued the Health Care Rule.

CRNAs and NPs, as midlevel providers, do not belong in a unit of registered nurses because their interests are more closely aligned with the category of other professionals rather than RNs. In other words, CRNAs and NPs at Mission are more closely aligned with physicians than they are with the RNs.

To work as an RN at Mission's acute-care hospital, the RN simply needs an Associate's degree and a registered nurses' license. Tr. Vol. 4, at p. 333; Pet'r Exs. 6 & 8. RNs are hourly employees at Mission. Tr. Vol 7, at p. 760. Generally speaking, the duties of an RN include, assisting advanced-level practitioners, e.g., physicians, surgeons, CRNAs, NPs, assess patients, carry out orders as prescribed by a physician or NP, educate patients, and provide bedside care. Tr. Vol. 7, at pp. 759, 794, 805, 820; Pet'r Exs. 6 & 8.

CRNAs, on the other hand, are advanced-level practitioners akin to a physician. To become a CRNA, the candidate must graduate from a doctorate program; CRNAs previously needed only a Master's Degree. Tr. Vol. 10, at p. 1202. CRNAs must also receive certification from the National Board of Registered Nurse Anesthetists. *Id.* at 1189. The job duties of a CRNA are starkly different than those of an RN. CRNAs are independent providers that provide

anesthesia and hemodynamic control of the patient for the surgeon and are responsible for selecting the anesthesia drugs to administer to the patient. Tr. Vol. 7, at p. 759. CRNAs perform other procedures that RNs can also not perform such as spinals, epidurals, nerve blocks, central venous catheters, and administer medications without a physician order. Tr. Vol. 10, at pp. 1202–03. Because of the vastly different scopes of practice, RNs cannot fill in for CRNAs or vice versa. Tr. Vol. 7, at p. 764. As detailed above, CRNAs do not fall within nursing supervision; rather, they, along with anesthesiologists, fall under the supervision of the Chief Anesthesiologist. CRNAs are salary employees and are paid significantly more than their RN colleagues. *Id.* at 765. Accordingly, CRNAs do not belong in a unit of registered nurses but would more appropriately belong to a unit of other professionals at the acute-care hospital.

NPs, like CRNAs, belong in a unit of other professionals rather than with RNs at the acute-care hospital. To become an NP, an individual must complete a doctorate program. Tr. Vol. 5, at p. 494. They must also receive certification from a national credentialing body corresponding to their specialty. Emp'r Ex. 17. NPs and physicians are interchangeable: both have a panel of patients, develop a plan of care for patients, write orders, review labs and make decision based on the lab, perform procedures, make referrals, prescribe medications, order diagnostic testing, and diagnose patients. Tr. Vol. 7, at p. 824–26; Tr. Vol. 8, at p. 876–77. RNs and NPs do not fill in for each other because they have vastly different scopes of practice. Tr. Vol. 7, at p. 829. As detailed above, NPs fall under the same supervision as physicians, and do not share supervision with RNs. NPs negotiate their salaries, and earn a salary as opposed to an hourly wage. Tr. Vol. 875–76.

The only similarities between RNs and the CRNAs and NPs is that they all have a registered nurses' license, and they all must advocate for patients like all hospital personnel. This is not sufficient to establish a community of interest. And the exclusion of the CRNAs and the

NPs is not arbitrary because they would more appropriately belong to a unit of other professionals according to the Health Care Rule.

D. A Mail-Ballot Election Is Appropriate Given the Covid-19 Pandemic

As stated on the Record, the Union strongly favors a mail-ballot election to protect all parties, including NLRB personnel during the Covid-19 pandemic. The Board recently held that the current crisis is an extraordinary circumstance warranting a mail-ballot election, stating:

> [W]e rely on the extraordinary federal, state, and local government directives that have limited nonessential travel, required the closure of nonessential businesses, and resulted in a determination that the regional office charged with conducting this election should remain on mandatory telework. Mandatory telework in the regional office is based on the Agency's assessment of current Covid-19 pandemic conditions in the local area.

Atlas Pacific Eng'g Co., Order Denying Review, NLRB Case No. 27-RC-258742 (May 8, 2020). The concerns expressed in *Atlas Pacific* are heightened in the instant matter given the facility in question is an acute-care hospital that is treating Covid-19 patients. In fact, on May 2, the State of North Carolina had its highest day of confirmed cases of 586. There have been 77 confirmed cases in Buncombe County and 4 deaths. These patients can be asymptomatic. A temperature screening at the door, as the Employer suggests, is not sufficient to protect the health of the Board agents conducting an election.

All Regional Directors that have handled R petitions in the last month have directed mail-ballot elections because of the extraordinary circumstances of Covid-19.

San Diego Gas & Electric, 325 NLRB 1143, 1145 (1998), held that a mail-ballot election was proper during a strike and other extraordinary circumstances. The Board has also found extraordinary circumstances when the unit is of seasonal workers, *Sitka Sound Seafoods*, 325 NLRB 685 (1998), and where the employees are geographically spread out, *Penn. Interscholastic Athletic Ass'n*, 365 NLRB No. 107 (2017). It is very clear from the Board's Rule that the Regional

Director has ultimate discretion on how to conduct matters pertaining to an election. No mitigation measures are sufficient to protect the health of the Board agents, and the health of the employees voting, which are paramount in this case. Board agents would have to travel to and from the election site, interacting with various personnel. Contact tracing is just not possible, particularly in the case of pre-symptomatic and asymptomatic individuals. As of the closing of the record, there were over 11,000 confirmed cases and 430 deaths in North Carolina. Those numbers are only increasing.

Merely providing face masks and temperature screens and just relying on employees' sense of social distancing is not sufficient, particularly when there have been protests about the lack of Personal Protective Equipment at the hospital and throughout the HCA system. It is simply insufficient to ensure the health and safety of these essential employees, and the Regional Director should follow the example of every other Regional Director, and as approved by the Board, and order a mail-ballot election.

The Union also asks that the Region set the election as soon as practicable, with a turnaround for the ballots of two to three weeks. It has been over two months since the Union filed its petition. And during that time, the Employer has exploited the Covid-19 crisis to subject nurses to a barrage of anti-union messages and captive audience meetings. The Region should immediately direct a fair and speedy election.

IV. CONCLUSION

For all the foregoing reasons, the NNOC/NNU respectfully requests the Region to find that the petitioned-for unit of all registered nurses at the Employer's acute-care hospital located at 509/428 Biltmore Ave., Asheville, NC 28801 is appropriate and immediately direct a mail-ballot election.

Dated: May 13, 2020

NATIONAL NURSES ORGANIZING COMMITTEE/NATIONAL NURSES UNITED (NNOC/NNU) LEGAL DEPARTMENT

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PROOF OF SERVICE

The undersigned hereby declares under penalty of perjury that I am a citizen of the United States, over the age of eighteen years and that my business address is 155 Grand Avenue, Oakland, California 94612.

On the date below, I served the following document:

POST-HEARING BRIEF BY PETITIONER
NATIONAL NURSES ORGANIZING COMMITTEE/NATIONAL NURSES UNITED (NNOC/NNU)

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I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on May 13, 2020, at Berkeley, California.

/s/ Rob Craven
Rob Craven

UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD
REGION 10, SUBREGION 11

MISSION HOSPITAL

Employer,

and Case 10-RC-257615

NATIONAL NURSES ORGANIZING COMMITTEE/
NATIONAL NURSES UNITED, AFL-CIO

Petitioner.
_____/

MISSION HOSPITAL'S POST-HEARING BRIEF

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I. INTRODUCTION

This matter arises from a Petition filed by National Nurses Organizing Committee-North Carolina/National Nurses United (the "Petitioner") on March 6, 2020, seeking to represent certain registered nurses working at Mission Hospital. Specifically, the petitioned-for unit is defined as "[a]ll full-time, regular part-time and per diem Registered Nurses employed by the Employer at its facility located at 509 Biltmore Ave., Asheville, NC 28801 and 428 Biltmore Ave., Asheville, NC 28801." (Bd. Ex. 1.)[1] The Acting Regional Director issued an order requiring the Employer to submit its Statement of Position by April 7, 2020 and scheduling a telephonic representation hearing to begin on April 14, 2020. The Employer timely filed a Statement of Position stating the petitioned-for unit is inappropriate for several reasons, including that it:

- fails to include registered nurses[2] who share a community of interest with included registered nurses;
- excludes registered nurses who do not have a distinct community of interest from included registered nurses;
- fails to include all registered nurses in the Employer's integrated enterprise operating in Buncombe County, North Carolina, consisting of MH Hospital Manager, LLC, Mission Health Community Multispecialty Providers, LLC, and MH Asheville Specialty Hospital, LLC; and
- appears to be based on the extent of organization in violation of section 9(c)(5) of the Act.

(Bd. Ex. 3.) Specifically, as the record evidence demonstrates, any appropriate unit must include all RNs employed by MH Hospital Manager LLC ("MH Manager"), Mission Health Community Multispecialty Providers, LLC ("MH Multispecialty Providers"), and MH Asheville Specialty

[1] In referencing the record in this matter, the following abbreviations to the record are used: a citation to the transcript shall be designated as (Tr.___); a citation to a Board Exhibit shall be designated as (Bd. Ex.___); a citation to an Employer Exhibit shall be designated as (Er. Ex.___); a citation to a Petitioner Exhibits shall be designated as (Pt. Ex.___); and a citations to a Joint Exhibit shall be designated as (Jt. Ex.___).

[2] The Employer refers to registered nurses as "RNs," "nurses," and "registered nurses," interchangeably throughout.

Hospital, LLC ("MH Asheville") in the integrated system within Buncombe County, North Carolina.

A telephonic hearing on the Petition commenced on April 14, 2020. At the outset of the hearing, the Petitioner stipulated to include many, but not all, of the nurses identified by the Employer as appropriately belonging in the unit. (Tr. 20:1-18.) The Acting Regional Director then directed the Hearing Officer to accept evidence at the hearing on the following issues: job classifications involving a community of interest; supervisory positions at issue; and joint and/or single employer status. (Tr. 21:23-25, 22:1-3.)

The hearing continued on April 15 – 17, 2020, and April 20 – 21, 2020. On April 22, 2020, the Hearing Officer postponed the hearing until April 27, 2020 due to technical difficulties with the telephonic hearing. The hearing concluded on May 6, 2020, covering 12 days of hearing.

During that time and despite initially stipulating to include many of the nurses designated by the Employer as appropriately in the unit, Petitioner later sought to withdraw that stipulation and return to its originally-petitioned-for unit at only two of the Employer's several facilities. The Acting Regional Director allowed that withdrawal. Based on the evidence adduced at the hearing, it is evident the petitioned-for unit is clearly inappropriate and any appropriate unit must contain the Employer's approximately 2,353 RNs in Buncombe County as set forth in Employer's Exhibits 2-4, as amended.

II. SUMMARY OF THE EMPLOYER'S POSITION

A review of the record evidence compels the immediate conclusion that the petitioned-for unit is not appropriate as it violates the requirement of Section 103.30(a)(1) of the Boards Rules and Regulations, which requires the inclusion of all registered nurses in a unit at an acute care hospital. As a result, the analysis shifts to determining an appropriate unit. The largely uncontroverted record supports the direction of an election in the Employer's proposed unit comprised of all registered nurses working in its integrated multi-facility enterprise in Buncombe County, North Carolina. The facts compel such an outcome for four reasons.

First, the petitioned-for unit is inappropriate under the Board's Health Care Rule because it does not include "all registered nurses." Absent extraordinary circumstances, the only appropriate unit of registered nurses is a unit that includes all registered nurses. The Employer operates a single, integrated enterprise employing registered nurses performing acute care throughout Buncombe County who are not encompassed within the petitioned-for unit. The Petitioner's proposed unit does not even include all registered nurses performing acute care services at the two discrete facilities referenced in the petition.

For example, the evidence shows Surgery Advanced Testing Unit (SATU) nurses and RN Care Managers (Case Managers) have offices in a building located at 1 Hospital Drive, but perform their regular duties while in physical proximity with and/or in direct collaboration with the nurses working at 509 Biltmore Avenue, the location for most, but not all of the beds for admitted patients of Mission Hospital. Similarly, the Employer's Certified Registered Nurse Anesthetists (CRNAs) work as part of a collaborative surgical nursing team at 509 Biltmore Avenue, but the Petitioner argues they comprise a separate group of professionals who should be excluded from the unit. The SATU nurses, Case Managers, and CRNAs all perform duties instrumental to the rendition of care

at 509 Biltmore. They share a community of interest with the registered nurses encompassed within the petitioned-for unit. Their exclusion from the petitioned-for unit renders it inappropriate.

Second, while the Board employs a presumption that a single-facility unit is appropriate, under well-established Board precedent, that presumption does not apply if the petitioned-for unit is a multi-facility unit. Here, the Petitioner indisputably seeks a multi-facility unit. Consequently, the single-facility presumption of appropriateness does not apply.

The Employer's proposed multi-facility unit is appropriate. The factors the Board deems relevant to a multi-location unit determination all favor the Employer's proposed unit. The facilities encompassed within Employer's proposed unit are geographically proximate. In addition, these facilities have centralized control of labor relations in that they share common personnel policies, fringe benefits, labor relations, and human resources. Employees within the Employer's proposed unit wear a common uniform, perform similar job duties, and all hold a registered nurse license. All employees within the Employer's proposed unit undergo the same recruitment, onboarding, orientation, and badging process when hired. Their wages are determined under centralized pay policies, they receive common fringe benefits, and their roles are set forth in job descriptions based upon a common, Mission Health-wide registered nurse job description. All employees' discipline and discharge are subject to centralized HR approval. All personnel records are maintained in a centralized electronic file.

There also is interchange of employees in that the Employer utilizes regular employee interchange and floating among facilities throughout Buncombe County. In addition, the Employer operates an internal staffing agency to fill RN vacancies. Employees who work at multiple locations in a single pay period receive a single check that aggregates hours worked across facilities and calculates overtime based on the aggregated figure. Mission Health employees can

seamlessly transfer to other positions throughout the Mission Health system with their seniority (hire date) and active progressive discipline remaining unaffected. Registered nurses are also eligible for system-wide awards and may participate in an optional clinical ladder program and system wide nursing committees.

Mission Health's functional integration includes a centralized pharmacy department, laundry/linen service, security, physical facilities department, marketing department, nurse education department, sterile processing department, and laboratory services department. The weight of record evidence establishes the Employer's proposed multi-facility unit is appropriate as all nurses encompassed within this unit share a community of interest. Conversely, no evidence supports the proposition that RNs within the petitioned-for unit share a separate and distinct community of interest from the RNs in the Employer's proposed unit. As such, the Region should direct an election in the Employer's proposed unit.

Third, Mission Health operates as a single employer comprised of three fully integrated and intertwined corporate entities (MH Manager, MH Multispecialty Providers, and MH Asheville). Any appropriate bargaining unit must include all registered nurses these three entities employ. The uncontroverted evidence establishes common ownership and centralized control over labor relations among the Employer's three business lines - MH Manager, MH Multispecialty Providers, and MH Asheville. All daily labor relations operations are centralized and controlled by a single, system-wide Vice President of Human Resources. All Mission Health business lines are subject to centralized management and control insofar as the head of each business line reports to the Employer's CEO. Furthermore, MH Manager, MH Multispecialty Providers, and MH Asheville's operations are inexorably intertwined. The evidence compels the conclusion that MH Manager, MH Multispecialty Providers, and MH Asheville constitute a single employer and the

Employer's proposed unit of all registered nurses who work for that single employer constitutes an appropriate unit.

Fourth, the facts establish the petitioned-for unit is based solely upon the Petitioner's extent of organization in contravention of Section 9(c)(5) of the Act. The petitioned-for unit notably inexplicably excludes a host of registered nurses within the Mission Health system who do not have a community of interest distinct from the hand-picked class of nurses encompassed within the petitioned-for unit. The facts developed over 12 days on the record, supports a determination that Petitioner's noteworthy exclusion of registered nurses who do not have a distinct community of interest from those within the petitioned for unit compels the conclusion that extent of organization forms the sole basis for the Petitioner's proposed unit. Under these circumstances, the Act prohibits a determination that the petitioned-for unit is appropriate.

With respect to unit composition, the primary issues concern the eligibility of Team Leads and the inclusion of nurse practitioners and CRNAs in the unit. Neither the Petitioner nor the Employer seek to exclude Team Leads from the voting unit. Insofar as no competent evidence adduced at the hearing suggests a contrary result, Team Leads should be afforded the opportunity to vote.

The Board has historically included nurse practitioners in registered nurse units. The evidence in this case supports adherence to precedent. Nurse practitioners and registered nurses have a similar educational background, hold a current RN license, perform many of the same duties, and apply many of the same skills. Their job description clearly states that nurse practitioners must work in compliance with the North Carolina Board of Nursing and perform the essential accountabilities of a Mission Health Professional Nurse. Moreover, nurse practitioners must work closely and collaboratively with other registered nurses in the rendition of care. Some

of the Employer's locations have only one nurse on staff. If no nurse is present a nurse practitioner is expected to perform the duties ordinarily performed by the absent nurse. Should the Employer have reason to terminate a nurse practitioner, a senior RN leader is involved in the decision since nurse practitioners hold a RN license and anyone who holds a RN license must ultimately report to a RN.

Though nurse practitioners have duties in addition to those performed by a RN, the ultimate responsibility for such duties – treatment, drug prescription, and patient diagnosis and care – resides with a licensed physician. Since, a nurse practitioner cannot otherwise perform any of these additional duties, this fact places nurse practitioners outside any health care unit other than registered nurse.

Likewise, Board precedent has consistently required the inclusion of CRNAs in a unit of registered nurses. Here the record evidence shows CRNAs are simply RNs with additional specialized training. As with nurse practitioners, any discipline and discharge decisions concerning CRNAs must involve a senior RN leader. CRNAs perform most of the same job duties found in the Employer's RN job description, they hold a RN license, satisfy the same standards of a "Mission Health Professional Nurse" under the Mission Health Guiding Principles as a registered nurse, and meet the same MERIT standards of performance as a registered nurse. The Employer's CRNAs function along with other surgical personnel, including registered nurses, as a medical team. CRNAs work collaboratively with RNs in the course of rendering patient care, including during handoffs between the preoperative, operative, and post-operative stages of a surgical case. During a surgical procedure, CRNAs work hand-in-hand with the circulating nurse. Ultimately the facts and decades of Board law support that the CRNAs should be include in the RN unit.

For these reasons, the Region should find the appropriate unit includes all nurses (including nurse practitioners and CRNAs) employed by MH Manager, MH Multispecialty Providers, and MH Asheville within the Mission Health system in Buncombe County. Since the Petitioner has represented that it would not proceed to an election on a unit other than that in the Petition (which is inappropriate), the petition should be dismissed.

III. BACKGROUND

Mission Hospital is the flagship, centralized facility within a larger healthcare system known as Mission Health system, a fully integrated health maintenance system operating in Western North Carolina. (Tr. 38:5-25; 39:1-4; Er. Ex. 1.) Mission Health offers a variety of healthcare services in Buncombe County, North Carolina by means of several interrelated business lines. *Id.* It operates an acute care hospital, which includes various out-patient clinics and centers; physician clinics/practices; a long-term, acute care hospital; a rehabilitation hospital; home healthcare; hospice; and an adult day care. (Tr. 34:25, 35:1-24, 42:21-25, 43:1-22.) The operations at all of these locations are fully integrated and include common recruiting, on-boarding, orientation, training, policies, job descriptions, education, payroll, compensation plan, benefits, awards, committees, pharmacy services, lab services, marketing, uniforms, badges, emergency preparedness plans, annual nursing report, laundry services, discounts, and even coffee shops. Significantly, these operations also share staff, including registered nurses (whose hours are aggregated for determining eligibility for overtime, benefits, and leave – regardless of work location), supervision/managers, equipment, logos, licensing, and patients. Moreover, internal transfers to any location in the system are seamless and allow the RN to maintain seniority and benefit-eligibility, and the Employer to continue any progressive discipline without interruption.

A. Mission Health's Lines of Business

All of Mission Health's lines of business ultimately report to Greg Lowe, Division CEO. (Er. Ex. 1.) The CEO of Mission Hospital reports directly to Mr. Lowe. (Er. Ex. 1). The physician clinics operate in a business line named "Physician Services Group," which also is referred to as "PSG" (formerly known as "Mission Medical Associates," or "MMA"). (Tr. 43:22-25, 44:1-15, 45:25, 46:1-4, 72:13-22.) PSG is managed by a Vice President who reports directly to Mr. Lowe. (*Id.*) Mission Health's rehabilitation hospital and the home healthcare and hospice services are referred to as CarePartners. (Tr. 39:5-25, 40:1-6.) A Mission Health Senior Vice President manages CarePartners and the long-term, acute care hospital, and that Senior Vice President also reports to Mr. Lowe. *Id.* Mission Health provides its various services through employees employed by three legal entities: MH Hospital Manager, LLC ("MH Manager"); MH Asheville Specialty Hospital, LLC ("MH Asheville"); and Mission Health Community Multispecialty Providers, LLC ("MH Multispecialty Providers"). (Er. Exs. 1-5.)[3] As the evidence discussed below demonstrates, these business lines are fully-integrated through interrelation of operations, centralized control of labor relations, interchange of employees, and geographic proximity.

[3] Attached hereto as Appendix A is a chart containing each of the locations described herein with the department, job title, number of nurses with that job title, and employer of each of the nurses in the Employer's proposed unit. The information contained therein does not constitute "new" evidence; rather, Appendix A is a summary of information admitted into the record evidence by the Hearing Officer. (*See* Er. Exs. 2-4.) Accordingly, Appendix A is not independent evidence and should be considered by the Region as argument. *See PCMC/Pacific Crane Maint.*, 359 NLRB 1206, fn. 37 (2013), *vacated*, *NLRB v. Noel Canning*, 573 U.S. 513 (2014) (denying motions to strike appendices containing summarizations of facts as this was simply argument and "advocacy is the purpose of briefs").

B. The Mission Hospital Campus

Located along the east and west sides of Biltmore Avenue in Asheville (Buncombe County), North Carolina is a group of the Employer's facilities known as the Mission Hospital Campus.

(Er. Ex. 7, referred to as the "Parking Map.")

As illustrated by that map, the Mission Hospital Campus consists of six "Facilities". Those "Facilities" are listed on the map as "Mission Hospital," commonly known as "Mission Main," (located at 509 Biltmore Avenue), the "St. Joseph Campus," (located at 428 Biltmore Avenue), 1 Hospital Drive, SECU Cancer Center (located at 21 Hospital Drive), 520 Biltmore Avenue, and Mission Imaging & Breast Center (located at 534 Biltmore Avenue). (Tr. 38:21-25, 39:1-4; Er. Ex. 7.)

1. Mission Hospital

Mission Hospital, or Mission Main as it is commonly known, is a free-standing building located at 509 Biltmore Avenue. It operates under a license issued by the State of North Carolina. (Pt. Ex. 17; Er. Ex. 18.) The license permits the operation of 733 acute care beds, 82 "psych" beds, six open heart surgery operating rooms, two C-Section operating rooms, six endoscopy operating rooms, 30 shared inpatient and ambulatory surgery operating rooms, and nine ambulatory surgery operating rooms. (Tr. 911:5-25; Er. Ex. 18; Pt. Ex. 17.) Due to space limitations, not all of those services are located within the four walls of 509 Biltmore Avenue. Specifically, the 82 "psych" beds are located on the St. Joseph Campus, located at 428 Biltmore Avenue (discussed in section B.2, below) and the nine ambulatory surgery operating rooms are located at Mission's Asheville Surgery Center, approximately three miles from Mission Main, at 5 Medical Park Drive (discussed in section C.1, below). (Er. Exs. 7-8, 18.) While Mission Main and the St. Joseph Campus are both located on the Mission Hospital Campus, they are on opposite sides of Biltmore Avenue and are not physically connected to each other. (Er. Ex. 7.) Mission Health also provides services to its patients at the 1 Hospital Drive building (discussed in section B.3, below) and the Cancer Center, located at 21 Hospital Drive (discussed in section B.4, below), both of which closer to Mission Main than the St. Joseph Campus is. (Tr. 110:17-22; Er. Ex. 7.) The Employer has other locations throughout Buncombe County. Indeed, as with Asheville Surgery Center, many of the other outpatient departments are not on the Parking Map. The nurses who work at Mission Main (509 Biltmore Avenue) are employed by either MH Manager or MH Multispecialty Providers. (See Er. Exs. 3-4). Notably, however, nurses employed by MH Asheville, who work at the St. Joseph Campus, come to Mission Main with their patients as needed. (Tr. 539:1-25, 540:1-25, 1087:23-25, 1088:1-5.)

2. St. Joseph Campus

The St. Joseph Campus houses three health care services, all employing RNs. Asheville, Specialty Hospital, a long-term acute care hospital ("ASH" or L-TACH), (Tr. 39:19-25, 40:1-6), is part of a business line known as CarePartners. (Tr. 39:5-20.) The nurses who work at ASH are employed by MH Asheville. (Er. Ex. 2). As noted above, there are 82 psychiatric or behavioral health beds at the St. Joseph Campus. (Tr. 909:14-25, 910:1-2.) The nurses caring for those patients are employed by MH Manager or MH Multispecialty Providers. (Er. Exs. 3 and 4) And, third, the inpatient Wound Care practice as well as part of the outpatient Wound Care practice (the remainder of which is located at 1 Hospital Drive) is also located on St. Joseph Campus's. (Tr. 58:23-25, 59:1-25, 60:1-3, 995:3-15, 997:6-25, 998:1-25, 999:1-11, 1000:12-22). Those nurses are also employed by MH Manager. (See Er. Ex. 3).

3. 1 Hospital Drive

The Facility at 1 Hospital Drive contains several departments and practices. As stated above, that Facility houses a Wound Care Clinic, located on the fourth floor. (Tr. 58:23-25, 59:1-25, 60:1-25, 61:1-9; Er. Ex. 7). The Wound Care Clinic is a part of PSG. (Tr. 76:6-15.) Nurses in the outpatient part of the Wound Care practice see patients at that location. (Tr. 58:23-25, 59:1-25, 60:1-25, 61:1-9.) For patients needing to utilize the hyperbaric oxygen chamber, which is located at the St. Joseph Campus, the Wound Care nurses and patients go from 1 Hospital Drive to the St. Joseph Campus. *Id.* The 1 Hospital Drive building is physically connected to The St. Joseph Campus by a pedestrian bridge that spans Biltmore Avenue. (Tr. 59:7-25, 60:1-3.) The pedestrian bridge is connected to the fourth floor of the 1 Hospital Drive building and to the second floor of the 428 Biltmore Avenue building on The St. Joseph Campus. (*Id.*) Wound Care nurses, their patients, and others use this bridge. *Id.* Patients in Mission Main who need wound care are seen by Wound Care nurses from the same practice but whose office is on The St. Joseph Campus. (Tr.

937:9-22.) The Supervisor of all the Wound Care nurses has his office at 1 Hospital Drive. (Tr. 994:20-25, 995:1-2-7.) Nurses working in the Wound Care practice are employed by either MH Multispecialty Providers or MH Manager. (Tr. 60:8-25, 61:1-9; Er. Ex. 3, pp 11-12 and Ex. 4, p 1.)

On the third floor of 1 Hospital Drive is Mission Health's Weight Management Clinic and Anticoagulation Clinic. (Tr. 62:18-25, 63:1-2.) In the Weight Management Center, patients are trying to either lose weight, and may be preparing for bariatric surgery, or keeping weight off post-bariatric surgery. (Tr. 63:3-13.) Bariatric surgery is performed at Mission Main, which is located across the street. (Tr. 63:14-17; Er. Ex. 7.) Nurses working in the Weight Management Center are employed by MH Multispecialty Providers. (Tr. 63:3-13, 1302:8-25, 1303:1-5; Ex. Ex. 4, p 1.)

On the second floor of 1 Hospital Drive is Mission Health's Care Management Department.[4] (Tr. 64:3-13.) This department is an **overflow** from Mission Main. *Id.* Care Management RNs work with patients admitted in Mission Main to plan for the next level of care to patients, assisting and coordinating post-discharge care such as entrance into a skilled nursing facility, nursing home, or rehabilitation. (Tr. 65:5-12.) Care Management RNs are employed by either MH Manager or MH Multispecialty Providers. (Tr. 64:14-25, 65:1-4, 65:13-20; Er. Ex. 3, pp 1-4 and Ex. 4, p 1.) Additionally, Mission Health's Medication Assistance Program and its Research Institute are located in this Facility. *Id.* Those nurses are employed by MH Manager. (Er. Ex. 3, p 8).

This Facility also houses a large nurse group known as SATU, or Surgery Advanced Testing Unit. (Tr. 360:14-22.) These nurses are employed by MH Manager. (Er. Ex. 3, pp 8-11). They work with patients scheduled for surgical procedures at Mission Main or Asheville Surgery

[4] Care Management is interchangeable with Case Management. (Tr. 64:14-20.)

Center that will require anesthesia, perform comprehensive pre-admission testing, schedule lab appointments and any necessary follow-through, and assist the anesthesiologist so that the patient is prepared for surgery. (Tr. 1049:6-20.) In the course of the pre-operative process, SATU nurses interact with many of nurses throughout Mission Health in Buncombe County. (Tr. 360:21-25, 361:1-25, 362:1-24, 363:2-25, 364:1-12, 1050:19-25, 1051:1.) These nurses float within Mission Health in Buncombe County. (Tr. 1051:17-25, 1052:1-24.)

Also at the Facility known as 1 Hospital Drive are the following areas with nurses employed by MH Manager: Clinical Performance Improvement (Er. Ex. 3, pp 4-5), Center for Clinical Advancement (Er. Ex. 3, pp 5-7), Diabetes (Er. Ex. 3, p 7), Disease Management (Er. Ex. 3, p 7), NCD OneHR (Er. Ex. 3, p 7), Outpatient Clinical Pharmacy Services (Er. Ex. 3, p 7), Quality and Safety (Er. Ex. 3, p 8), and System Care Management (Er. Ex. 3, p 11). There is also a physician orthopedic/trauma practice at that Facility, with a nurse practitioner employed by MH Multispecialty Providers. (Er. Ex. 4, p 1).

Finally, on the first floor of 1 Hospital Drive is Mission Health's coffee shop, an independent physician practice, and an Outpatient Behavioral Health Clinic. (Tr. 70:5-9.)

4. SECU Cancer Center

Mission Health's Cancer Center, also referred to as SECU, is located at 21 Hospital Drive. (Tr. 70:10-18, 457:19-21; Er. Ex. 7.) Laura Kerzwick is the Director of the Cancer Center and has administrative oversight and operational duties at that location, as well as at Mission Health's Hope Women's Cancer Center, located at 100 Ridgefield. (Tr. 70:19-25, 71:1-10.) The Cancer Center is a five-story building with four numbered floors (the first floor through the fourth floor) and a lower level. (Tr. 71:11-14.) The Cancer Center is a freestanding building with its own parking lot. (Tr. 458:10-14; Er. Ex. 7.)

On the fourth floor is Mission Medical Oncology, which is a part of PSG. (Tr. 71:15-21, 458:15-22, 459:7-11.) There are approximately ten RNs who work at Mission Medical Oncology. Nine nurses are employed by MH Manager (Tr. 71:22-25, 72:1-7; Er. Ex. 3, pp 16-17.) A nurse practitioner is employed by MH Multispecialty Providers. (Tr. 72:13-25, 73:1, Er. Ex. 4, p 2.)

On the third floor is Mission Main's outpatient cancer center and adult infusion services. (Tr. 76:16-25, 459:12-18.) There are approximately 46 treatment spaces on this floor. (Tr. 77:1-7.) This department is known as a "HOP-D," which stands for Hospital Out Patient Department. *Id.* There are registered nurses working in this department who are employed by MH Manager. (Tr. 77:7-11; Er. Ex. 3, pp 17-18.) There is a conference room on the third floor in which nurse staffing meetings occur monthly. (Tr. 460:7-19.) There are 12 nurses working in the adult infusion clinic. (Tr. 460:20-25.)

On the second floor is another PSG practice called Mission Cancer Specialists, which is Mission Health's surgical oncology practice, as well as Pediatric Hematology Oncology Practice, which is also a PSG. (Tr. 77:12-17, 462:5-24.) The latter PSG has nurses and nurse practitioners employed by MH Manager. (Tr. 462:14-24; Er. Ex. 3.) The second floor is also home to Mission Health's Pediatric Cancer Practice and Pediatrics Infusion Center. *Id.* There are registered nurses working in these practices who are employed by MH Manager. (Tr. 77:18-22; 459:24-25, 460:1-6; Er. Ex. 3.) In order to work in the pediatric area, all nurses and nurse practitioners must obtain a chemo biotherapy card. (Tr. 463:21-25, 464:1-25.) There are six nurses in the pediatric clinic. (Tr. 460:20-25.)

The first floor, which is on street level, contains Mission Health's outpatient pharmacy, its Simple Therapy Department, a gift shop, and a coffee bar. (Tr. 77:23-25, 78:1-3.) The Integrative Health office is also located on the first floor. (Tr. 459:12-18.)

On the lower level is Mission Health's cancer imaging center and radiation therapy clinic. (Tr. 78:9-15.) There are registered nurses working in the radiation therapy clinic who are employed by MH Manager. (Tr. 78:16-25; Er. Ex. 3, p 18.) This is a Mission Main-based practice. (Tr. 458:23-25, 459:1-6.) These nurses report to Leslie Divine. (Tr. 461:15-21.)

Even though the nurses who work at SECU are separated by different floors, these nurses work together as one unit. (Tr. 460:7-14.) The Nurse Manager for the Cancer Center holds monthly staff meetings amongst all nurses working at SECU because the information is the same for all nurses. (Tr. 460:7-19.)

5. 520 Biltmore Avenue

Mission Health's Access Control Department is located at the Facility listed on the map of Mission Hospital Campus as 520 Biltmore Avenue. (Er. Ex. 7.) That Facility is the central source for badges and keys for the entire health system. (Tr. 79:1-7; Er. Ex. 7.) Indeed, no matter an employee's work location, all employees working in the Employer's proposed unit obtain their identification badge and keys from this location. (Tr. 79:21-25, 80:1.) This is true for employees working for MH Manager, MH Asheville, and MH Multispecialty Providers. (Tr. 79:8-21.)

6. Mission Imaging & Breast Center

The sixth Facility listed on the Mission Hospital Campus parking map consists of Mission Imaging Center Asheville and Mission Breast Center Asheville, and is located at 534 Biltmore Avenue. (Tr. 80:2-10; Er. Ex. 7.) There is one registered nurse working at this location, who is employed by MH Manager. (Tr. 80:9-12; Er. Ex. 3.)

C. <u>Additional Facilities in Buncombe County</u>

As referenced above, in addition to the six Facilities on the Mission Hospital Campus, Mission Main operates in several other Facilities in Buncombe County which are equally as integrated as those on campus. They include:

1. Asheville Surgery Center

Asheville Surgery Center ("ASC"), located at 5 Medical Park Drive, is an outpatient ambulatory surgery center. (Tr. 56:23-25, 57:1-25, 58:1-5.) ASC is a HOP-D and shares licensure with Mission Main. (Tr. 912:1-9.)[5] There are nine operating rooms at ASC. *Id.* ASC is located three miles from Mission Main. (Er. Ex. 8.) RNs working at ASC are employed by MH Manager. (Er. Ex. 3, pp 24-28.) In addition, certified registered nurse anesthetists ("CRNAs"), who are employed by MH Multispecialty Providers, work at ASC. (Tr. 352:21-25, 353:1-4; Er. Ex. 4.)

2. Hope Women's Cancer Center

Hope Women's Cancer Center ("Hope") is located at 100 Ridgewood Court, approximately 8 miles from Mission Main. (Tr. 81:8:20.) Hope Women's Cancer Center is a multi-story building that contains the Hope Women's Cancer Center practice, outpatient labs, a CarePartners rehabilitation location, imaging, and an outpatient infusion center. *Id.* The outpatient infusion clinic at Hope Women's Cancer Center is a HOP-D and the registered nurses who work in that department are employed by MH Manager. (Tr. 81:21-25, 82:1-8; Er. Ex. 3, pp 12-13.) With one exception, the nurses who work in the physician practice at Hope are also employed by MH Manager (Tr. 82:9-20; Er. Ex. 3.) One nurse who works at the Hope Women's Cancer Center practice is employed by MH Multispecialty Providers (Er. Ex. 4, p 1.), but all of the nurses are under direction of Karen Olsen, the Chief Nursing Officer of Mission Hospital. (Tr. 82:21-25: 83:1-18.)

[5] The North Carolina Department of Health and Human Services licenses hospitals and separately licenses ambulatory surgical facilities. ASC is not listed on the Department's roster of licensed ambulatory surgical facilities as it is covered by Mission Main's license. (Tr. 912:20-25, 913:1-12; Er. Exs. 18 and 19.)

3. Mission Children's Hospital Reuter Outpatient Center

Mission Children Hospital Reuter Outpatient Center ("Reuter") is Mission Health's outpatient center for children and is located at 11 Vanderbilt Park. (Tr. 83:17-25, 84:1-25, 85:1-12; Er. Ex. 8.) It is approximately 2 miles from Mission Main. *Id.* Reuter is a HOP-D that includes ten physician practices. (Tr. 214:10-16.) Mission Health has made Reuter a shared space in which everyone can utilize and leverage resources, while caring for the same patients among various practices and subspecialties. (Tr. 86:15-25, 87:1-8.) Registered nurses employed by MH Manager work at Reuter. (Tr. 85:13-25; 86:1-3; Er. Ex 3, p 13-15.) This includes a registered nurse from a physician practice known as Olson Huff Center, located at 890 Hendersonville Road. (*See* Er. Ex. 3, p 13 and Er. Ex. 4, p 12) Working with these nurses are nurse practitioners who are employed by MH Multispecialty Providers. (Tr. 86: 4-13; Er. Ex. 4, p 2.)

4. CarePartners Campus

Located at 68 Sweeten Creek Road, approximately two miles from Mission Main, is the CarePartners Campus. (*See* Er. Ex. 8). It includes a Rehabilitation Hospital, a Home Health care business, an inpatient Hospice business (known as Solace), an outpatient Hospice business, and an internal, Mission Health-dedicated staffing pool business. (Tr. 39:5-25, 40:1-6.) This facility shares staff with other facilities and gets most of its patients from other Mission facilities and from within the Campus. (Tr. 225:7-25, 230:2-11, 232:7-25, 233:1-25, 234:1-3, 1098:24-25, 1099:1-17, 1108:3-18, 1156:13-24, 1159:17-25, 1160:1-17, 1161:2-25, 1162:1.) The nurses there are employed by MH Manager. (Er. Ex. 3, pp 153-167.) The CarePartners Campus also houses four physician practices having nurse practitioners who are employed by MH Multispecialty Providers. (*See* Er. Ex. 4, p 12).

5. PACE

In addition to locations at the St. Joseph Campus and CarePartners Campus, the CarePartners line of business also includes a Facility at 286 Overlook Road in Asheville known as PACE. (Tr. 39:5-19, 579:9-25, 580:1-5.) PACE is an acronym for Program of All-inclusive Care for the Elderly. (Tr. 1129:6-18, 1312:19-25, 1313:1.) PACE is an open floor facility and contains an adult day care center, a primary care clinic, and a therapy clinic. (Tr. 1313:5-24.) The nurse practitioners at the clinic are employed by MH Multispecialty Providers (Er. Ex. 4, pp 2-3) while the other nurses at that Facility are employed by MH Manager. (Er. Ex. 3, p 19.) Some of the nurses at PACE see patients in the home as well; all nurses are cross-trained to do so. (Tr. 1314:10-24.)

6. 5 Vanderbilt Park Drive

Mission Health includes a Facility located at 5 Vanderbilt Park Drive in Asheville specializing in heart services. There are two physician practices at that Facility, which is two miles from Mission Main. (Tr. 289:5-13; Er. Ex. 8.) One is called Asheville Cardiology Associates ("ACA") and is a large PSG providing outpatient cardiology services to adult and pediatric patients. *Id.* ACA has nurses, including nurse practitioners, working in the practice. (Tr. 291:11-24.) ACA also uses nurses from Mission Main employed by MH Manager to assist its nurses or fill in for its nurses, and its nurses also assist other physician practices. (Tr. 671:1-7, 23-25, 672:1-25, 673:1-22, 674:2-20, 674:25, 676:1-20, 677:13-25, 678:8-25, 679:2-25, 680:1-10, 16-20, 683:3-14; *see* Er. Exs. 14, 15, 16.) All of the ACA nurses and nurse practitioners are employed by MH Multispecialty Providers. (*See* Er. Ex. 4, pp 4-5.) Within that same Facility is another heart practice known as Heart Path. (Tr. 253:1-19.) All of the nurses in that practice are employed by MH Manager. (Er. Ex. 3, p 29.)

7. MMA Mission Urology

MMA Mission Urology is located at 100 Victoria Road in Asheville and is one of the PSG practices. (Tr. 80:16-25, 81:1-7.) The single nurse working at this location is employed by MH Multispecialty Providers. (Er. Ex. 4, p 1.)

8. 890 Hendersonville Road

Mission Health provides outpatient neurology services at 890 Hendersonville Road in Asheville. (Tr. 261:22-25, 262:1-14, 293:13-25, 294:1-25, 871:22-24.) That Facility contains physician practices that specialize in outpatient neurology. *Id.* All but one of the nurses there are employed by MH Multispecialty Providers. (Er. Ex. 4, pp 12-13). One RN is employed at the practice known as Olson Huff Center, but works at Reuter and she is employed by MH Manager. (Er. Ex. 3, p 13.)

9. 900 Hendersonville Road

Also on Hendersonville Road, at 900 Hendersonville Road, is physician practice called Mission Infectious Disease. Both RNs in that practice are employed by MH Multispecialty Providers. (Er. Ex. 4, p 13.)

10. 1940 Hendersonville Road

This Facility includes a Health Education Center and additional Care Managers who are tele RNs meaning some of their work is done via electronic means. These nurses are employed by MH Manager. (Er. Ex. 3, pp 15-16.)

11. Outpatient Spine Center

Mission Health operates an outpatient spine center, located at 7 Vanderbilt Park in Asheville. (Tr. 624: 10-16.) This Facility has two physician practices at that location, Interventional Spine and Mission Spine Center. It is two miles from Mission Main, and the nurses working at this Facility are employed by MH Manager. (Er. Ex. 3, p 167, and Ex. 8.)

12. 310 Long Shoals Road

This Facility includes two physician practices: Mission Family and Internal Medicine and My Care Now. (Tr. 652:7-16, 663:3-17, 1307:19-25, 1308:1) It is located 8.2 miles from Mission Main in Asheville. (Er. Ex. 8.) The nurses at this Facility are employed by MH Multispecialty Providers. (Er. Ex. 4, p 3.)

13. Asheville Family Medicine

Mission Health also includes a physician practice at 41 Oakland Road in Asheville, known as Asheville Family Medicine. The nurses there are employed by MH Multispecialty Providers. (Er. Ex. 4, p 3.). It is located 0.8 miles from Mission Main. (Er. Ex. 8.)

14. Mission Surgery

Located at 14 Medical Park Drive, in Asheville and 3.1 miles from Mission Main, is Mission Surgery. (Er. Ex. 7.) This Facility is a physician practice having RNs employed by MH Manager and one nurse practitioner employed by MH Multispecialty Providers. (*See* Er. Ex. 3, p 15 and Er. Ex. 4, p 2.)

15. 2 Medical Park Drive

The Facility at 2 Medical Park Drive in Asheville houses Mission Health's WorkWell operation as well as a PSG Lactation Outpatient clinic. (Tr. 169:26, 170:1-25, 171:1-6, 987:10-20.) This facility is 3 miles away from Mission Main. (Er. Ex. 8.) Mission WorkWell is the central employee health for all of Mission Health. (Tr. 169:25, 170:1-6.) All employees are processed through WorkWell for pre-employment prescreening and drug testing. (Tr. 170-1-25, 171:1-20.) Mission Health nurses go to WorkWell to receive flu shots, as well. (Tr. 329:17-20.) It has a nurse practitioner employed by MH Multispecialty Providers and a RN employed by MH Manager. (*See* Er. Ex. 3, p 16 and Er. Ex, 4, p 2.) The nurses at the Lactation practice are employed by MH Manager. LLC. (Er. Ex. 3, p 16). As set forth in more detail below, these nurses frequently go to

Mission Main to see patients. (Tr. 987:17-25, 989:1-7.) All of the equipment at the lactation clinic is purchased by Mission Main, and Mission Main is responsible for the Facility's maintenance. (Tr. 991:1-8.)

16. Carolina Vascular

This Facility is located at 222 Asheland Avenue, in Asheville, 0.9 miles from Mission Main. (Er. Ex. 8). This is a part of PSG. (Tr. 280:15-17.) The nurses at this facility are employed by MH Manager (Er. Ex. 3, pp 18-19), but as set forth in more detail below, often pick up shifts at other Mission locations, such as Mission Main, Mission Vein Clinic and My Care Now. (Tr. 253:2-25,. 254:1-25, 255:1-4, 662:20-24, 663:3-24, 667:17-25, 668:1-14; 1308:17-25, 1309:1-7 Er. Exs. 3, 14-15.)

17. 400 Ridgefield Court

Located near the Hope Cancer Center (which is at 100 Ridgefield Court in Asheville) is a Facility housing five nurses. (Tr. 448:5-23.) There is a distribution center at this location, which sends medications to Mission Main, and there is a retail pharmacy available to all employees who use Mission Health insurance. (Tr. 448:12-23, 449:3-23.) There are two registered nurses at the Facility who are employed by MH Multispecialty Providers, an RN educator and a nurse working in the Central Primary Care Triage practice. (*See* Er. Ex. 4, p 3.) Four RNs at other practices at that same Facility are employed by MH Manager. (Er. Ex. 3, p. 19-20.)

18. 2100 Ridgefield Boulevard

This Facility contains a women's specialty group at 2100 Ridgefield Boulevard in Asheville. It has a RN midwife who is employed by MH Multispecialty Providers. (Er. Ex. 4, p 2.)

19. 63 Monticello Road

This Facility which houses the Mission Family Medicine – Weaverville practice is 10.6 miles from Mission Main in Weaverville, North Carolina. (Er. Ex. 8.) There are three nurse practitioners at that Facility, all of whom are employed by MH Multispecialty Providers. (Er. Ex. 4, pp 11-12.)

20. 1388 Sand Hill Road

Located 9.1 miles from Mission Main in Candler, North Carolina is a physician clinic called Mission My Care Plus. (Er. Ex. 8.) The nurses there are employed by MH Multispecialty Providers. (Er. Ex. 4, p 2.)

21. 2695 Hendersonville Road

Also on Hendersonville Road, in Arden, is a Facility known as Vista Family Health. The nurse practitioners there are employed by MH Multispecialty Providers. (Er. Ex. 4, p 2.)

IV. LEGAL ARGUMENT

The Region's analysis of the bargaining unit issues in this case must begin by determining whether the bargaining unit proposed by the Petitioner is appropriate. The only answer supported by the record evidence is "no." The Petition seeks "[a]ll full-time, regular part-time, and per diem registered nurses, employed by the Employer at its facility at 509 Biltmore Ave., Asheville, NC 28801 and 428 Biltmore Ave., Asheville, NC 28801," excluding "[a]ll other employees, guards, supervisors and other professional employees as defined in the Act." (Bd. Ex. 1.) The Petitioner's proposed unit seeks to gerrymander certain groups of registered nurses while excluding a significant number of registered nurses who share the same employer, skills, and working conditions, *i.e.* a community of interest. As such, the proposed unit is an arbitrary grouping which does not comport with NLRB bargaining unit precedent or principles.

In more detail, the Petitioner's proposed unit is inappropriate because it does not comply with the Board's Health Care Rule ("Rule"), which requires that except in extraordinary circumstances, the "only appropriate unit[]" of registered nurses is one that includes "[a]ll registered nurses." 29 C.F.R. § 130.30(a)(1). The Petitioner's unit also is inappropriate because it is a multi-facility unit, yet it excludes registered nurses in other facilities who do not have a distinct community of interest from nurses in the petitioned-for unit. Finally, the Employer submits that the Petitioner's unit is inappropriate because it is based solely on the Petitioner's extent of organization, contrary to the prohibitions of Section 9(c)(5) of the Act, 29 U.S.C. §159(c)(5).

A. The Petitioned-For Unit Is Inappropriate Under The Board's Health Care Rule As It Does Not Include All Registered Nurses.

The Board's Rule provides that, absent "extraordinary circumstances," in acute care hospitals there are only eight appropriate bargaining units, one of which is "[**a]ll** registered nurses." 29 C.F.R. § 103.30(a)(1) (emphasis supplied). Significantly, the Petitioner stipulated that "[t]he Employer is engaged in the operation of an acute care hospital providing healthcare services." (J. Ex. 1.) Yet, the petitioned-for unit fails to include all of the RNs employed by the Employer. As is addressed in more detail in this Section, below, the Rule's definition of "acute care hospital" includes hospitals that provide services in addition to acute care services, "as, for example, long term care, outpatient care, psychiatric care, or rehabilitative care." 29 C.F.R. § 103.30(f)(2). The petitioned-for unit fails to include these nurses providing these additional services and is therefore inappropriate.

As is discussed below in Section IV.B.3., the evidence demonstrates that the Employer is a single, integrated enterprise which employs registered nurses engaged in acute care who are not contained in the petitioned-for unit. Pursuant to Section 103.30(f)(2), the registered nurses working in the Employer's other facilities throughout Buncombe County must be included in any

appropriate unit. The petitioned-for unit, however, does not contain these nurses, further highlighting the inappropriateness of the petitioned-for unit.

Even assuming *arguendo* the registered nurses who provide these additional services throughout Buncombe County should not be included in the unit, the Petitioner's proposed unit is inappropriate because it does not include all nurses providing acute care services at Mission Main. *See* 29 C.F.R. §103.30(f)(2).

It is undisputed that at 1 Hospital Drive, MH Manager employs SATU, or pre-surgery, registered nurses, who are necessary members of the surgical team at Mission Main and ASC. (Tr. 360:1-17, 1049:6-20, 1221:22-24.) These nurses work directly with patients having surgical procedures at Mission Main or ASC who will require anesthesia. Indeed, the SATU nurses perform comprehensive pre-admission testing, pre-surgical testing, schedule lab appointments and any necessary follow-through, and assist the anesthesiologist so that the patient is prepared for surgery. (Tr. 360:23-25, 361:1-13, 1049:6-20.) Thus, as the SATU nurses are an integral part of the acute care surgical process at Mission Main, they must be included in any appropriate unit. *Id.* The Petitioner, however, excluded SATU nurses from the petitioned-for unit. (*See* Bd. Ex. 1.) For this reason alone, the Petitioner's proposed unit is not appropriate.

Similarly, the Petitioner's petitioned-for unit excludes RN Care Manager I and RN Care Manager II nurses who work in the Case Management Department. These RNs have an office at 1 Hospital Drive, but work mostly in Mission Main at 509 Biltmore Avenue to provide care to admitted patients. (Tr. 64:3-20; Er. Ex. 3.) The Case Management Department reports to John Ehrhart, Director of Case Management, whose office is in Mission Main. (Tr. 67:2-13; 915:11-19.) Due to the space limitations at Mission Main, the Case Management Department was moved to the 1 Hospital Drive building. (Tr. 940:21-25, 941:1.) Every day the RN Care Managers leave

the 1 Hospital Drive building and go to the Mission Main building at 509 Biltmore Avenue to perform their jobs. (Tr. 940:15-19.) The Case Managers "do not have a desk job. Their job is to work on [the] nursing unit in order to help patients get to their next level of care, or to be discharged from the hospital." (Tr. 940:20-25, 941:1-7.) Given their involvement in the acute care function of Mission Main, Case Managers must be included in any appropriate unit, as well.

The Board's Notice of Proposed Rulemaking with respect to the Rule, reprinted at 284 NLRB 1515, makes clear that units of employees working for an acute care hospital remain subject to the Rule even if the employees' offices or work locations are located outside of the facility housing the acute care hospital. In particular, the Board observed, "The ballooning costs of new construction, as well as increased technology, have resulted in many instances in hospitals' moving administrative offices outside the health care facility into existing buildings at other locations …." 284 NLRB at 1563. The Board nonetheless concluded that absent extraordinary circumstances, a unit including "[a]ll business office clerical employees," working for an acute care hospital is the **only appropriate unit**, regardless of whether the employees are located in the health care facility or in buildings at other locations. 29 C.F.R. §103.30(a)(6). Consequently, the fact that the offices of the SATU nurses and the RN Care Manager I and RN Care Manager II nurses who work in the Case Management Department are in the 1 Hospital Drive building as opposed to Mission Main or 428 Biltmore Avenue is irrelevant.

Finally, the petitioned-for unit also fails to include CRNAs who work at Mission Main in the operating rooms alongside registered nurses the Petitioner seeks to include in the unit.[6] The Petitioner will contend that because CRNAs have Master's degrees, they are inappropriate for

[6] CRNAs are employed by Multispecialty Providers. (Er. Ex. 4.) As is discussed in Section IV.C, below, MH Manager, MH Asheville, and Multispecialty Providers are an integrated enterprise and consequently a single employer. As result, that CRNAs are employed by Multispecialty Providers rather than MH Manager is irrelevant to their inclusion in the unit.

inclusion within the unit and, instead, represent a separate group of professionals. Yet, there is no evidence that CRNAs share a community of interest with any other group of purported professionals. Instead, it is undisputed that all CRNAs are required to hold a RN license, and are overseen by the North Carolina Board of Nursing, the same as every registered nurse the Petitioner contends should be in the unit. (Tr. 712:3-11; 1189:16-23); (Er. Ex. 17.)

Like the SATU nurses, CRNAs are a part of the surgical team at Mission Main. (Tr. 362:7-10.) CRNAs have pre-op interactions with patients including verification of anesthesia and surgical consent, for which CRNAs must sign-off. (Tr. 363:21-25, 364:1-12.) Thereafter, the CRNA brings the patient to the surgical suite, provides assistance to transition the patient onto the operating table, places monitors on the patient, and assists with intubation. (Tr. 364:17-25, 365:1-20.) The CRNA remains in the surgical suite throughout the operation, working throughout, along with the rest of the surgical team, including the circulating nurse. (Tr. 366:10-25, 367:1-25, 368:1-25, 369:1-25, 370:1-4.) Upon completion of the procedure, the CRNA and the circulating nurse handoff the patient to the post-anesthesia care unit ("PACU") nurse, who is also an RN. (Tr. 399:9-19, 1194:2-13.) During the post-surgery handoff, the circulating nurse and CRNA debrief the PACU nurse regarding the patient's physical state. (Tr. 399:20-25, 400:1-8, 1194:2-13.) Thus, given their performance of these duties within Mission Main, the Rule dictates that CRNAs must be included within the appropriate unit, as well. *See Trustees of Noble Hosp*. 218 NLRB 1441, 1444 (1975) (including CRNAs within bargaining unit of RNs.)

Based on the foregoing, even under the most restrictive reading of the Rule that limits its scope to only all registered nurses providing care to patients admitted to an acute care hospital, the SATU nurses, the Case Management nurses, and the CRNAs must be included within any appropriate unit. The fact that the SATU nurses and the Case Management nurses work out of the

1 Hospital Drive building is not a basis for excluding them from the unit. The Petitioner seeks a unit of registered nurses working in 509 Biltmore Avenue and 428 Biltmore Avenue. These buildings are across the street from one another. The 1 Hospital Drive building is "without a question" closer to Mission Main at 509 Biltmore Avenue, than is the St. Joseph Campus at 428 Biltmore Avenue. (Tr. 942:18-20.) Further, the 1 Hospital Drive building is on the same side of Biltmore Avenue as is the Mission Main building. (Er. Ex. 7.) In contrast, the St. Joseph Campus is located on the opposite side of Biltmore Avenue. In addition, the 1 Hospital Drive building is physically connected to building at 428 Biltmore Avenue by means of a pedestrian bridge. In light of the close proximity of the 1 Hospital Drive building and Mission Main and the fact that 1 Hospital Drive building is physically connected to 428 Biltmore Avenue, there clearly is no legitimate reason to exclude the SATU nurses and the Case Management nurses who work out of the 1 Hospital Drive building.

The Petitioner's failure to include these nurses in its petition underscores the petitioned-for unit is not appropriate under **any** circumstance. Thus, the Region should reject the Petitioner's petitioned-for unit and perform its own evaluation of unit appropriateness. As articulated below, the Employer's proposed unit of all RNs working in the Employer's multi-facility integrated enterprise in Buncombe County is appropriate, and thus, the unit for which the Region should direct the election.

Indeed, the undisputed evidence demonstrates that the Employer employs registered nurses at facilities other than 509 Biltmore Avenue and 428 Biltmore Avenue. The highly integrated nature of the Employer's operation within Buncombe County is best described by Joe Rudisill, Chief Operating Officer for Mission Hospital. When asked to describe Mission Main, Mr. Rudisill stated that:

> Because it's landlocked, the hospital includes multiple sites outside the four walls of the hospital, whether it had been office buildings or physician practice offices, or ambulatory sites, or whether outpatient diagnostic centers or laboratories that are throughout the immediate area and also throughout [Buncombe County]…"

(Tr. 34:25, 35:1-24.) Thus, when determining the scope of the Employer's operations in relation to the Rule, the Region must consider Mr. Rudisill's unrebutted testimony that the acute care services provided by the Employer extend beyond simply 509 Biltmore Avenue.

This understanding is confirmed by the Petitioner's stipulation to the type of service in which the Employer engaged, *i.e.*, "the operation of an acute care hospital." Significantly, the stipulation does not state that the extent of the acute care services is limited to 509 Biltmore Ave. or 428 Biltmore Ave. Moreover, the evidence reveals that other facilities of the Employer that are physically separate from Mission Main support the operation of this acute care hospital. For example, Asheville Surgery Center regularly deploys nurses to Mission Main for surgical procedures, such as retina procedures. (Tr. 353:24-25, 354:1-23, Tr. 357:8-24.) Whether a procedure is moved from Asheville Surgery Center to Mission Hospital is a very nurse-driven process, dependent upon the circumstances. (Tr. 355:21-25, 356:1-12.) Further, patients at Mission Main who need wound care are seen by nurses who work out of 1 Hospital Drive. (Tr. 58:23-25, 59:1-25, 60:1-25, 61:1-9, Tr. 76:6-15; Er. Ex. 7). Thus, the scope of acute care services is not limited to just those performed at Mission Main and is, instead, supported by other facilities within Buncombe County.

Further, that the Employer operates facilities that are more outpatient in nature, such as the Cancer Center, does not foreclose application of the Rule. Under Section 103.30(f)(2), these facilities should be included in the unit with the Employer's acute care operation. Specifically, the Rule defines "acute care hospital" to "include those hospitals operating as acute care facilities even if those hospitals provide such services as, for example, long term care, outpatient care, psychiatric

care, or rehabilitative care." 29 C.F.R. §103.30(f)(2). Accordingly, the Region must include the Employer's other facilities providing such services. Moreover, the Rule does not prohibit the Region from including these facilities simply because of their physical separation from Mission Main, and neither the Rule nor extant Board law necessitate such a conclusion. Mission Health's use of multiple facilities to provide patient care is a product of circumstance, as it is undisputed that Mission Main is landlocked. The Region, therefore, should apply the Rule to determine that any appropriate bargaining unit must contain **all** RNs employed by the Employer, regardless of physical location.

Indeed, at the hearing, the Employer introduced evidence that it employs registered nurses at the facilities at the following locations, **in addition** to those contained in the Petition: (1) 1 Hospital Drive; (2) 100 Ridgefield Court; (3) 11 Vanderbilt Park Drive; (4) 14 Medical Park Drive; (5) 1940 Hendersonville Road; (6) 2 Medical Park; (7) 21 Hospital Drive; (8) 222 Asheland Avenue; (9) 286 Overlook Road; (10) 400 Ridgefield Court; (11) 5 Medical Park Drive; and (12) 68 Sweeten Creek Road, among others. (*See* Er. Ex. 3; Appendix.) As explained above, these integrated facilities support and further the services provided by the acute care hospital and, thus, are appropriate for inclusion within the proposed unit.

While the Petitioner may argue that application of the Rule to Mission Main forecloses the Region from considering other facilities within Mission Health, such an argument lacks support. As an initial matter, it does not appear the Board has elected to address the issue of whether the Rule "applies not only to single acute-care hospital facilities, but also to systems of health care facilities … which include acute-care hospitals, as well as other types of health care services." *Virtua Health, Inc.,* 344 NLRB 604, 605 (2004). Some Regional Directors have issued decisions finding that the appropriate unit was limited to an acute care hospital, to the exclusion of outlying

facilities, but these decisions are distinguishable on the facts at issue. Indeed, in each of these decisions, the acute care services performed by employer were limited to the acute care hospital, which is certainly not the case in this matter. Moreover, "unreviewed regional directors' decisions have no precedential value." *In re of Fedex Home Delivery*, 2006 NLRB LEXIS 123, *4 (2006). The Region, therefore, need not consider or rely upon these decision in determining application of the Rule.

In *St. Anthony's Hospital*, 2000 NLRB Reg. Dir. Dec. LEXIS 307 (2000), the parties stipulated that each of the two hospitals at issue was an acute care facility, while the employer's other facilities were non-acute. In addition, each hospital was located at one single, self-contained address, not in multiple buildings. The Regional Director determined based on the parties' stipulation that the appropriate unit was limited to the nurses at the two acute care hospitals. *Id.* at *5-8. In this matter, there is no such stipulation. In addition, here, the nurses providing acute care services are located in multiple facilities. Significantly, the employer in *St. Anthony's* did not assert that it was a single employer, nor was there evidence of significant integration, as the evidence in this matter demonstrates.

While a Regional Director had occasion to analyze the Rule in *Prime Healthcare Services*, 2016 NLRB Reg. Dir. Dec. LEXIS 127 (2016), the facts are different than those presented by the instant matter. Indeed, in *Prime*, the Regional Director analyzed whether the Rule applied to satellite facilities and, if so, whether inclusion of nurses from those facilities would render an existing unit non-conforming for purposes of deciding whether to direct a self-determination election. *Id.* at *7. After analyzing the extant Board law, the Regional Director conditioned his decision "in the absence of any authority that Rule should be applied to healthcare networks that include various facilities in addition to an acute care hospital." *Id.* at *10-11. The Regional

Director, therefore, determined that these facilities should not be subject to the Rule's requirements unless they were a "combined, single facility." *Id.* at *11. Unlike the evidence regarding the Employer's outlying facilities in this case, the Regional Director determined that the facilities and hospital were geographically separated and were "not so integrated that they should be treated as a single combined facility." *Id.* Here, the Employer's facilities are not so geographically separated and do operate as a single integrated facility.

Finally, in *Pleasant Valley Hospital, LLC*, 2019 NLRB Reg. Dir. Dec. LEXIS 96 (2019), a Regional Director applied the Rule to determine that the petitioned-for unit of all nurses working in a single-site acute care facility was presumptively appropriate and concluded the employer failed to demonstrate "extraordinary circumstances," such that the Regional Director could make a unit-determination by adjudication. Significantly, the employer did not argue nor did the Regional Director consider whether the employer was a single, integrated employer such that it satisfied the definition of "acute care hospital" under Section 103.30(f)(2). *Id.* Instead, the employer argued that its operation was substantially similar to those in *Child's Hospital*, 307 NLRB 90 (1992), which found extraordinary circumstances as a result of the physical joinder of an acute care facility and nursing home. *Id.* at *15-20. This is fundamentally different from the facts in the instant matter as applied to the Rule where the nurses providing acute care services are located in multiple facilities, which are highly integrated. Accordingly, these decisions are not applicable in this case.

In light of the fact that the acute care functions of Mission Hospital are located in several facilities, including in 428 Biltmore Avenue and in 1 Hospital Drive, which include other services, such as "long term care [and] outpatient care," 29 C.F.R. §103.30(f)(2), in this case the Rule should be applied to require inclusion of all registered nurses of the Employer throughout its system of

health facilities in Buncombe County. This is especially true due to the high degree of integration of services and interchange of employees throughout the system as is discussed in more detail below.

As the Rule applies to all of the Employer's facilities within Buncombe County, all nurses working in those facilities must be included in the unit. A party may challenge the presumptive appropriateness of the bargaining unit containing all RNs employed by the Employer, but it may do so only if there are "extraordinary circumstances." § 29 C.F.R. 103.30(a). The Petitioner bears the "heavy burden" of demonstrating that the Employer's operations involve "unusual and unforeseen deviations" from the normal pattern seen in acute care facilities, and the Board interprets this exception narrowly. 53 Fed. Reg. 33933; *See* Memorandum from NLRB General Counsel on Health Care Unit Placement Issues to Regional Directors, Officers-in-Charge, and Resident Officers (June 5, 1991). The Petitioner has stipulated the Employer is an acute care hospital, and it cannot satisfy its heavy burden to demonstrate extraordinary circumstances.

Based on the foregoing, it is plain that the Petitioner's petitioned-for unit is inappropriate and the Region should reject it as it fails to comply with the Rule.

B. The Petition Seeks a Multi-Facility Unit, And a Multi-Facility Unit is Appropriate.

As the Petitioner's petitioned-for unit is inappropriate, because at a minimum it fails to include nurses who perform acute care services at Mission Main, the Region must next determine the appropriate unit. Based on the overwhelming evidence adduced at the hearing, it is evident that the Employer's proposed unit including all RNs working for MH Manager, MH Asheville, and MH Multispecialty Providers working for Mission Health in Buncombe County is appropriate. As thoroughly discussed below, this evidence demonstrates that the registered nurses in the Employer's proposed unit do not have a separate and distinct community of interest from those

registered nurses working at Mission Main and St. Joseph Campus and, therefore, these nurses must be included in any appropriate unit.

1. The Region Should Not Apply the Single-Facility Presumption Because the Petition Explicitly Seeks Multiple Facilities.

At the outset, it is likely that the Petitioner will argue that the single-facility presumption should be applied, thereby presuming that the petitioned-for unit is appropriate and requiring the Employer to come forward with evidence to rebut that presumption. This argument is as unavailing as the petitioned-for unit, on its face, is a multi-facility unit.

"[T]he appropriate analytical starting point is to determine whether the unit the Union seeks to represent constitutes a single facility. The Board has generally defined as single facility as being coextensive with a single building." *St. Vincent Healthcare*, 2009 NLRB Reg. Dir. Dec. LEXIS 202, *37 (2009). (citing *Visiting Nurses Ass'n of Cent. Ill.*, 324 NLRB 55 (1997), *Child's Hosp., Samaritan Serv. Corp.*, 307 NLRB 90 (1992) (concluding that a hospital, nursing home, and service center constitute a single facility where they are physically connected and operationally integrated)). "The Board has long held…that a single-facility unit geographically separated from other facilities operated by the same employer is presumptively appropriate for the purpose of collective bargaining even though a broader unit might also be appropriate." *Manor Healthcare Corp.* 285 NLRB 224, 225 (1987).

In this instant matter, the single-facility presumption should not apply because the Petitioner is not seeking a single-facility unit. Indeed, as the Petition demonstrates, the Petitioner is seeking to represent RNs working at two separate locations. (Bd. Ex. 1.) Moreover, the unrebutted evidence demonstrates that Mission Main and the St. Joseph Campus (*i.e.*, the buildings identified by the Petition) are physically separate, as well, and do not share any physical

connections (*i.e.*, pedestrian bridges, walkways, or tunnels). (Er. Ex. 7.) Instead, these entities are separated by a major public road. (Tr. 224:12-17, 533:7-15; Er. Ex. 7.)

Moreover, "a single-facility unit [must be] geographically separated from other facilities operated by the same employer …." *Manor Healthcare Corp.* 285 NLRB at 225. Here, neither 509 Biltmore Avenue nor 428 Biltmore Avenue is geographically separated from the Employer's other facilities on the Mission Hospital Campus. Indeed, as is discussed above in Section III.B.3., 1 Hospital Drive is physically connected to 428 Biltmore Avenue by means of a pedestrian bridge used by nurses and patients. In addition, 1 Hospital Drive is close enough that employees who work in that building come to the cafeteria located in the Mission Main building located at 509 Biltmore Avenue for their meal break on a daily basis.(Tr. 943:1-7; 943:21-25, 944:1-6.) Employees from the 21 Hospital Drive building and the St. Joseph Campus also come to the Mission Main cafeteria for meals. *Id.* The facilities identified by the Petitioner in its Petition are not geographically separated from the Employer's other facilities on the Mission Hospital Campus. Consequently, the single-facility presumption does not apply.

Accordingly, the petitioned-for unit is accurately described as a multi-facility unit and, therefore, does not involve the single-facility presumption found in *Manor Healthcare*. *See University of Pittsburg Med. Ctr.*, 313 NLRB 1341, 1342 (1994) (finding single-facility presumption did not apply where petitioned-for facility consisted of eight buildings, several of which were separated from one another.)

Further, the single-facility presumption "is not appropriate when the Petitioner seeks to represent a multi-facility unit." *Memorial Healthcare,* 2005 NLRB Reg. Dir. Dec. LEXIS 101, *27 (2005) (citing *Stormont-Vail Healthcare, Inc.,* 340 NLRB 1205 (2003)). "When a union petitions for a multilocation bargaining unit, the presumption in favor of a single facility unit has

no applicability." *Sleepy's Inc.*, 355 NLRB 132, 134 (2010), *abrogated by New Process Steel, L.P. v. NLRB*, 560 U.S. 674 (2010) (holding Board must maintain delegee group of three in order to exercise delegated authority of Board); *see St. Mary's Healthcare*, 2014 NLRB Reg. Dir. Dec. LEXIS 139, *27-28 (2014) (concluding single-facility presumption does not apply where parties agree that petitioned-for unit includes RNs at two hospitals). The Region, therefore, should not apply the single-facility presumption on this basis, alone.

Even if the Region entertains that Mission Main and the St. Joseph Campus are a single facility (which it should not), the evidence adduced at the hearing demonstrates that the Employer has satisfied its burden of "showing…functional integration so substantial as to negate the separate identity of the single-facility unit." *St. Louis Children's Hosp.*, 2002 NLRB Reg. Dir. Dec. LEXIS 244, 9 (2002). Discussing the factors that should be evaluated when making this determination, the Board stated in *Trane*, 339 NLRB 866, 867 (2003):

> To determine whether the single-facility presumption has been rebutted, the Board examines a number of community of interest factors, including (1) central control over daily operations and labor relations, including the extent of local autonomy; (2) similarity of employees, functions, and working conditions; (3) the degree of employee interchange; (4) the distance between locations; and (5) bargaining history, if any exists.

"[T]he Board also examines the extent to which a single-facility unit creates an increased risk of work disruption or other adverse impact upon patient care should a labor dispute arise." *Mercy Sacramento Hosp.*, 344 NLRB 790 (2005); *see West Jersey Health Sys.*, 293 NLRB 749, 751 (1989) (finding a labor disruption in one facility would adversely affect the care available at other facilities where those facilities relied upon one another for services, such as where a facility sends patients to another facility for radiology testing and where one facility relies upon another facility to provide food services). Each of these factors are discussed at length, below, which conclusively

establish that should the single-facility presumption apply, it has been rebutted and only a multi-facility unit is appropriate.

2. The Board's Analysis in *Stormont-Vail* Applies to Determine the Multi-Facility Appropriate Unit.

When a multi-facility unit is petitioned for, as the Petitioner here has, the Board will find the unit to be arbitrary and inappropriate unless the employees in the petitioned-for unit share a community of interest that is distinct from employees located in the employer's other facilities. *Bashas' Inc.,* 337 NLRB 710, 711 (2002), cited with approval in *Stormont-Vail Healthcare,* 340 NLRB 1205, 1207 (2003). In *Stormont-Vail,* the Board sought to determine whether the petitioned-for employees shared a community of interest distinct from that of other employees located in other facilities. That case involved substantially similar facts to the instant case, and the Board found that:

> [i]n determining whether a multi-facility unit is appropriate the Board evaluates the following factors: employees' skills and duties; terms and conditions of employment; employee interchange; functional integration; geographic proximity; centralized control of management and supervision; and bargaining history.

Id. 1207 (citing *Alamo Rent-A-Car*, 330 NLRB 897 (2000); *NLRB v. Carson Cable TV,* 795 F.2d 879, 884 (9th Cir. 1986)); *see Laboratory Corp. of Am. Holdings*, 341 NLRB 1072, 1082 (2004). The Board has determined that this is the "Board's traditional multi-facility community of interest analysis." *Multicare Health Sys.*, 2019 NLRB LEXIS 33, fn. 1 (2019.) (citing *Laboratory Corp. of Am. Holdings,* 341 NLRB 1072 (2004)).

In *Virtua Health, Inc.*, 344 NLRB 604, 606 (2005), the Board, in addition to the factors identified in *Stormont-Vail,* identified the skill backgrounds of the employees at issue and well as the avoidance of the proliferation of bargaining units in health care institutions as factors to be considered. In evaluating these factors, the Board seeks to determine whether the "RNs in the unit

found appropriate share a community of interest distinct from the excluded RNs." *Stormont*, 340 NLRB at 1207 (citing *Bashas' Inc.*, 337 NLRB 710, 711 (2002)).

As this matter involves the determination of the scope of a multi-facility unit, the Region should apply this analysis to determine whether RNs working at Mission Main and the St. Joseph Campus have a separate and distinct community of interest from other RNs in Mission Health. Based on the evidence adduced at the hearing, the RNs in the petitioned-for units **do not** have a distinct community of interest from other Mission Health RNs. Thus, all of the registered nurses in the Employer's proposed unit must be included in the multi-facility unit that the Petitioner proposes.

3. The Bargaining Unit Determination In This Case Is Controlled By *Stormont-Vail*, *Virtua Health*, and *Laboratory Corporation*.

The facts in this case are nearly identical to the facts in *Stormont-Vail*. Similar to the Employer herein, Stormont-Vail operated a highly centralized comprehensive regional medical system that consisted of a hospital complex in Topeka, Kansas; seven other buildings within a six (6) block radius of the hospital complex including an outpatient surgery center, a heart center, physician offices, human resources and central finance offices and clinics; an outlying psychiatric facility; outlying clinics; outlying community nursing centers and a helicopter ambulance service based at locations outside of the main campus. *Stormont-Vail*, 340 NLRB at 1205.

The Regional Director in *Stormont-Vail* found that an employer-wide multi-facility unit of approximately seven hundred (700) full-time and regular part-time registered nurses was appropriate, but excluded registered nurses working at Stormont-Vail's outlying psychiatric facility, outlying clinics, and community nursing centers. *Id* at 1205. The Board reversed the Regional Director's bargaining unit determination in *Stormont-Vail* and included registered nurses at the outlying psychiatric facility, the outlying clinics and the community nursing centers in the

unit found to be appropriate, reasoning that the evidence failed to establish that the registered nurses in the unit found appropriate by the Regional Director shared a community of interest **distinct** from the excluded registered nurse. *Id*. at 1207 (emphasis supplied).

The Board's decision in *Virtua Health, Inc*. 344 NLRB 604 (2005) also supports the Employer's position herein that a system-wide unit of all its registered nurses in Buncombe County is the appropriate unit in this case. Virtua operated a comprehensive regional medical system consisting of four (4) acute care hospitals, a non-acute care hospital, a Mobile Intensive Care Unit including a paramedic division, a Medical Command, an aero medical unit, a freestanding surgery facility, an ambulatory services center, a cardiac performance center, a family health center, a center for health and fitness, a women's center and a home health services unit in southern New Jersey. *Id.* at 604. Virtua employed one hundred-fifty (150) paramedics in its ambulatory services department. *Id.*

The union in *Virtua* sought a system-wide unit of paramedics while the Employer contended that the unit must include all of its technical employees. *Id*. The Regional Director found that the petitioned-for unit of paramedics was appropriate. The Board reversed and held that a unit limited to paramedics was not an appropriate unit for bargaining. *Id* at 13. Of particular note in *Virtua* was the Board's reliance on the Rulemaking factors relative to technical employees, namely, skill backgrounds and the avoidance of the proliferation of bargaining units, in concluding that a paramedics-only unit was inappropriate. As in *Virtua,* the skill backgrounds of the Employer's registered nurses herein militate for an all-encompassing registered nurse unit as does the avoidance of proliferation of bargaining units factor. Indeed, the Petitioner's unit, if accepted, would result in exclusion of wholesale groups or departments of the Employer's registered nurses who would otherwise be eligible for inclusion.

Finally, in *Laboratory Corporation of America Holdings*, 341 NLRB 1079 (2004), the Regional Director determined that a unit of phlebotomists, administrative team leads, technician teach leaders, and reference clerks at seven of the employer's Patient Service Centers ("PSCs") located in southeastern New Jersey was appropriate. The employer contented that the smallest appropriate unit must include employees at all 29 PSCs that comprised the employer's Southern New Jersey Region. *Id.* at 1079. After performing the multi-facility unit analysis, the Board concluded that while "the employees in petitioned-for unit shared a community of interest…the evidence fails to establish that it is separate and distinct from the community of interest they share with the other employees of the Employer's Southern New Jersey Region. *Id.* at 1083.

The following are the factors upon which the Board relied to make its bargaining unit determination in *Stormont-Vail*, all of which are present in this case. Each factor militates toward a multi-facility unit comprised of all Mission Health registered nurses in Buncombe County. These factors are as follows:

a. Geographic Proximity.

In *Stormont-Vail*, the excluded psychiatric unit at Stormont West was two miles from the main campus; the excluded freestanding clinics ranged from three to sixty miles away from the hospital complex; and one of the excluded community nursing centers was six blocks from the complex and the other was located in a suburb of Topeka. 340 NLRB at 1205, 1209. Conversely, there were three included facilities that were ten miles, twenty-five to thirty miles, and seventy miles away from the hospital complex. *Id*. at 1208.

In the instant matter, the evidence overwhelming demonstrates that the Employer's proposed unit is appropriate based on the geographic proximity of the facilities sought to be included by the Employer. First, there are six facilities in Employer's proposed bargaining unit in close geographic proximity to one another on the Mission Hospital Campus: (A) Mission Main,

located at 509 Biltmore Avenue; (B) the St. Joseph Campus, located at 428 Biltmore Avenue; (C) the medical office building, located at 1 Hospital Drive; (D) SECU Cancer Center, located at 21 Hospital Drive; (E) 520 Biltmore Avenue; and (F) Mission Imaging & Breast Center, located at 534 Biltmore Avenue. (Er. Ex. 7.) All of these facilities share common labor relations, and are overseen by a single Vice President of Human Resources. (Tr. 112:8-14.)

Likewise, the distance between Mission Health's other twenty-one facilities, including the CarePartners inpatient rehab hospital and Asheville Surgery Center, in relation to Mission Main demonstrate that they too are appropriate for inclusion. (Tr. 58:11-22; Er. Ex. 8.) Indeed, the farthest facility is only 10.6 miles away from Mission Main, and the majority of the facilities are within 3.1 miles of Mission Main. (Er. Ex. 8.) *See generally, Laboratory Corp.* 341 NLRB at 1083 (geographic proximity supports finding a broader unit where clinics were generally within 10 miles of each other and no more than 25 miles apart).

At the outset, it is important to note the Petitioner's petitioned-for unit encompasses facilities that are part of a larger campus. (Bd. Ex. 1.) This strongly rebuts the argument that any additional sites, particularly on the Mission Hospital Campus, are inappropriate. It is undisputed that registered nurses who work at 1 Hospital Drive also work within departments located at Mission Main, as well as PSG, and are employed by MH Manager or MH Multispecialty Providers, (Tr. 58:1-25, 59:1-25, 60:1-25, 61:1-25, 62:1-25, 63:1-25, 64:1-25, 65:1-25, 66:1-25, 67:1-25, 68:1-25, 69:1-25, 70:1-25; Er. Exs. 3, 4, 7.) Despite sharing this close geographic proximity with Mission Main and the St. Joseph Campus, the Petitioner failed to include 1 Hospital Drive in its Petition. Thus, the only conclusion to be drawn from this fact is that the Petitioner's petitioned-for unit is based solely on the extent to which registered nurses have organized. Section 9(c)(5) of the

Act is an explicit statutory prohibition against basing a unit appropriateness determination *solely* upon a Petitioner's extent of organization, and will be discussed more fully below.

Importantly, the geographic proximity of the facilities encompassing the Employer's proposed bargaining unit allow the Employer's patients to receive related services from several such facilities at the same time. (Tr. 58:23-25, 59:1-25, 60:1-3.) For example, because 1 Hospital Drive houses the Wound Care Clinic, and the St. Joseph Campus houses a hyperbaric oxygen chamber treatment center, patients move back and forth between the two buildings for treatment using the pedestrian bridge that connects the two buildings. *Id.* Given their proximity to one another, the Employer employs nurses who work at both the Wound Care Clinic and the hyperbaric oxygen chamber treatment center located across from one another. (Tr. 60:17-25, 61:1-4; Er. Exs. 3-4.) Thus, these nurses, who are employed by either MH Manager or MH Multispecialty Providers work alongside one another, shoulder-to-shoulder, to provide patient care in the same geographic location. (Tr. 61:5-9.) Similarly, RNs from Mission Main go to the Cancer Center (located on the Mission Hospital Campus across the street from Mission Main but which Petitioner seeks to exclude) to certify their chemotherapy readiness, and the Cancer Center RNs go to Mission Main to treat Cancer Center patients needing treatment on the weekends. (Tr. 459:1-6, 489:14-25, 490:1-25, 419:1-14.)

Further, there are clinics contained within Mission Main that are associated with physician groups, such as Asheville Cardiology Associates. (Tr. 239:7-25, 240:1-10, 247:4-12.) Notably, ACA is a mere two miles from Mission Main. (Er. Ex. 8). Of course, this close proximity is hardly surprising in light of the evolution of health care, which has resulted in having fewer procedures done in the inpatient setting and more in ambulatory sites located outside of hospitals. (Tr. 34:25, 35:1-16.) The Hospital-based ambulatory sites include outpatient labs, imaging centers, infusion

centers, physician practice offices, and other types of clinics such as wound care, weight management, and the hyperbaric oxygen clinics. (*Id*.)

All of these facilities sought to be included by the Employer are in close geographic proximity to the facilities in the Petition, thus this factor militates in favor of a multi-facility unit comprised of all RNs working at Mission Health in Buncombe County.

b. Employee Interchange.

In *Stormont-Vail*, the Board noted that there was record evidence of interchange between the off-campus psychiatric unit (Stormont West) and the senior diagnostic psychiatric unit on the main campus. 340 NLRB at 1208. There was also some evidence of interchange of registered nurses among the clinics and between the outlying clinics and departments on the main campus. *Id*. at 1209. There was also a float pool of licensed practical nurse ("LPNs") and patient care technicians in *Stormont-Vail* that floated throughout the facilities, including between the clinics. *Id*. at 1209.

Here, there is significant evidence that the Employer utilizes nurses interchangeably throughout Buncombe County. Indeed, the undisputed evidence demonstrates that RNs float to and from Mission Main, and between Mission facilities in Buncombe County. *See* Section IV.B.3.e.i, below. Thus, interchange of nurses occurs frequently and, as shown below, not limited to just RNs. Further, it is undisputed that the Employer maintains a single staffing pool which Mission Health utilizes to fill holes in schedules at different locations. *Id*.

Further, in *Stormont-Vail*, in determining the geographic scope of an RN unit at a multi-facility healthcare employer, the Board noted employees in non-RN positions floated between facilities. The Board found this floating by employees in non-RN positions was evidence the RNs at the different facilities should be included in the same unit because they did not have distinct community of interest. Thus, evidence about non-RN employees is relevant to the appropriateness

of the unit proposed by the Employer. Here, the evidence demonstrates that employees other than RNs (*e.g.*, surgical techs) have floated through Mission Health. (Tr. 402:21-25, 403:1-10; 1222:3-10; 1225:15-23, 1226:9-25, 1127:1-17.)

This factor, therefore, militates in favor of a multi-facility unit comprised of all RNs working at Mission Health in Buncombe County

c. Registered Nurses' Skills and Duties.

In *Stormont-Vail,* the Board found that the work of the registered nurses at Stormont West and the senior diagnostic psychiatric unit at the hospital was similar. *Id.* at 1207. The Board also found that the skills and functions of the registered nurses in the outlying clinics were similar to those of the registered nurses included in the unit. *Id*. at 1208.

In this matter, the evidence demonstrates the nurses in the Employer's proposed bargaining unit must meet the same criteria for employment and perform similar job duties on a day-to-day basis, regardless of facility. In fact, all of the nurses in Employer's proposed bargaining unit are required to have a license to practice from the North Carolina Board of Nursing. (Tr. 242:25, 243:1-5, 330:10-19.) This is true regardless of whether there may be specific educational requirements of particular position. (Tr. 333:10-13.) For example, a registered nurse must have a college degree to be licensed, either an Associate or Bachelor degree. (Tr. 108:8-19.) Similarly, a nurse practitioner, who has a Master's degree, is a registered nurse. (Tr. 108:16-19.) A registered nurse whose primary duties are in a physician practice or clinic, is required to possess either an Associate or Bachelor degree and are required to maintain their registered nurse's license. (Tr. 109:13-18.) Licenses from the North Carolina Board of Nursing are valid for two years from the date of issuance and, therefore, require renewal. (Tr. 330:10-19.)

In addition to the fact that all registered nurses are required to be licensed by the State of North Carolina, all of the nurses in the Employer's proposed bargaining unit perform similar job

duties on a daily basis. Indeed, the Employer's nursing positions all have the same goal of curing the patient from a nursing perspective. (Tr. 606:6-23.)

Significantly, Mission Health has a basic RN job description from which all other nursing job descriptions are built. (Tr. 1349:19-25, 1350:1-3; Er. Ex. 20, pp 20-000489 – 000492.) Moreover, these job descriptions apply throughout Mission Health, including but not limited to Mission Main, CarePartners, and the St. Joseph Campus. (Tr. 1349:10-17; Er. Ex. 20, pp 20-000489 - 000492.) For example, the testimony is undisputed that nurses at Home Health, PACE, Rehabilitation Hospital, and Solace perform virtually all of the duties set forth on the Staff RN job description used at Mission Main and its HOP-Ds, including assessing patients, creating and updating nursing care plans, educating patients, advocating for patients, delegating care, documenting care, and collaborating with others about the patient's care. (Tr. 462:25, 463:1-11, 544:16-25, 545:1-7, 1081:18-25, 1082:1-25, 1083:1-6, 1084:3-20, 1085:3-25, 1086:1-25, 1087:1-3, 1103:12-25, 1104:1-9, 1124:20-25, 1125:1-25, 1126:1-25, 1127:1-25, 1128:1-25, 1129:1-2, 1156:15-25, 1-2, 1241:11-25, 1242:1-25, 1243:1-25, 1244:1-6, 1312:19-25, 1313:1, 1314:25, 1315:1-25, 1316:1-25; *see also* Pet. Ex. 8.) In fact, the overlapping duties of all the nurses in the Employer's proposed unit were conceded by Petitioner's witnesses, with each of them, including the CRNAs and nurse practitioners, testifying point by point that they performed the very duties set out in the basic RN job description. (*Compare* Pet. Ex. 8 *with* Tr. 758:11-24, 759:2-13, 761:7-11, 772:23-25, 774:5-8, 775:16-25, 776:1-18, 777:13-25, 778:1-25; 779:1-3; 781:17-25, 782:1-16, 783:4-9, 784:9-20, 785:1-4; 786:21-25: 787:14-19, 805:17-25, 806:1-3, 813:25, 814:1-25, 815:1, 819:23-25, 820:1-22, 823:13-23, 824:19-25, 825:1-13, 826:23-25, 827:1-13, 831:21-25, 832:1-4, 834:15-25, 835:1-22, 836:1-25, 837:25, 838:1-2, 840:21-25; 841:1-16, 844:14-17, 846:17-25, 847:1-11; 848:23-25, 849:1-9, 851:17-20, 852:2-16, 858:14-18.). The mere fact that an ICU RN

may perform some duties that a RN on the Mother/Baby unit does not is inconsequential to the Board's analysis that these nurses all share common duties and skills, and thus have a common interest.

By way of additional comparison, Continuum Care Managers 1 and 2, who are employed by MH Multispecialty Providers, are responsible for helping to manage individual patients to whom they are assigned, while providing the appropriate next level care regardless of whether that patient is at a clinic or one of the hospitals. (Tr. 68:7-13; Er. Ex. 3.) Likewise, RN Care Managers 1 and 2, who are employed by MH Manager, are responsible for helping to assign patients to the next appropriate level of care post-admission/discharge. (Tr. 68:14-18.) Ultimately, despite the different titles and working at different locations, the primary duties of Care Managers are to assign the next appropriate level of care, whether it's in a hospital or outpatient setting, in order to help provide direct access to these patients. (Tr. 68:19-25, 69:1-20.)

Moreover, the primary duties of nurses throughout the Mission Health system remain largely the same, and only vary slightly depending on the department where they work. For example, VAD Coordinators, who are registered nurses, provide general care to patients who have had ventricular assist device implants by meeting with patients in Mission Main, Asheville Cardiology Associates, and ASH, assisting in pre-operation, following up with patients after surgery, and providing ongoing support to these individuals as the primary contact person during appointments. (Tr. 248:4-21, 255:16-25, 256:1-9.)

Similarly, a registered nurse at Reuter will also assist providers with in-office procedures, and perform post-procedure tasks to support the patient, such as filling out prior authorizations for prescribed medications or procedures ordered by the provider, providing assistance to medical assistants, answering questions that a family may have, and serving as the ongoing contact for

patients. (Tr. 330:22-25, 331:1-14). At 1 Hospital Drive, Care Management RNs work out of the same location, perform the same work, and report to the same Director of Care Management, John Ehrhart. (Tr. 65:21-25, 66:1-25, 67:5-13.) Care Management RNs are employed by MH Multispecialty Providers, but do not have different skills than those nurses employed by MH Manager. (Tr. 69:5-20.)

Significantly, the evidence supports the fact that differences in job titles do not change the primary job duties of RNs in the Employer's proposed unit. For example, the difference between an RN Physician Practitioner and an Advance Practitioner ED TR is that the former performs services in the physician's practice itself, while the latter works in the Emergency Room. (Tr. 109:13-25,110:1-9.) The job duties of nurses in the Employer's proposed bargaining unit are so similar that the staff has interchanged positions and facilities depending on the Employer's needs and nurses' availability. (Tr. 98:8-25, 99:1-8.) The fact that nurses can, and frequently do, interchange between facilities and can perform the job duties at those facilities further demonstrates that, putting aside the difference in job titles, the nurses in the Employer's proposed bargaining unit have a high degree of similarity between the actual job duties they perform. *Id.*

This factor, therefore, militates in favor of a multi-unit facility.

d. Terms and Conditions of Employment.

The Board in *Stormont-Vail* noted that the employer's personnel policies applied equally to employees in the outlying clinics and that the employer's human resource department played the same role at the outlying clinics with respect to the hiring, terminations and discipline as with the other departments and clinics. 340 NLRB at 1208. The Board in *Stormont-Vail* noted that all registered nurses had the same pay scales and participated in the same new employee orientation and training. *Id.* There was an interoffice mail system at Stormont-Vail that made deliveries to outlying clinics twice a day. *Id.* All Stormont-Vail employees participated in employer-wide

holiday parties and picnics and were eligible for system-wide service awards. *Id*. The Board further noted in *Stormont-Vail* that all employees, regardless of work location, were sent to the employee health nurse at the human resource center for non-emergency health care during working time. *Id*. at 1206. Stormont-Vail had a centralized computer and software system maintenance and centralized purchasing of supplies, etc. *Id*. There was a cafeteria in the hospital complex that was open to all employees and offered all employees a discount. *Id*.

Since the registered nurses within Mission Health in Buncombe County enjoy identical terms and conditions of employment, all of the factors supporting the same conclusion reached in *Stormont-Vail* are present in this matter and are discussed below. This factor, therefore, militates heavily in favor of a multi-facility unit.

i. Mission Health's Policies Apply to All Employees.

Mission Health's policies apply to all employees within Buncombe County, regardless of what position the employee holds, or at what location the employee works. (Tr. 185:19-25, 186:1-6; 197:12-18.) Importantly, these policies include all employment-related policies, which are housed on an intranet to which all employees have access. (Tr. 186:1-20.) Indeed, these e-policies have taken the place of the traditional "handbook" used by many employers. (Tr. 158:17-25, 159:1-25, 160:1.) By way of example only, Mission Health maintains uniform policies on attendance, corrective action, and substance abuse, all of which are provided to every new hire in the Mission Health system and apply uniformly thereto. (Tr. 163:5-25, 164:1-16, 197:7-11; Er. Ex. 10.)

Mission Health's centralized human resources information system is known as "Lawson". (Tr. 93:22-25, 94:1-9, 588:1-7.) Lawson allows employees to perform certain HR related functions such as updating their address, changing their tax deductions, checking any available paid-time off balances, and other similar tasks. (Tr. 158:7-16; Er. Ex. 10.)

Significantly, having uniform employment polices also means that the length of time for which a nurse must wait to enroll in benefits is the same for every nurse, regardless of location or classification. (Tr. 162:22-25, 163:1-4; Er. Ex. 10.) It also means that Mission Health uses standard forms, including, for example, for issues such as patients' rights. (Tr. 156:10-25, 157:1-5; Er. Ex. 10.)

ii. Mission Health's Hiring Process is the Same for All Employees.

(a) Recruitment is the same.

Further evidence of the interrelation of operation, which establishes that the excluded nurses do not have a distinct community of interest, is that the record evidence demonstrates that recruitment across the Employer's proposed unit is centralized and supported by a single recruitment team that is comprised of several talent acquisition consultants and managed by a single Director of Recruiting. (Tr. 117:3-17, 136:4-7; Er. Ex. 9.) For example, recruitment for the Cancer Center at 21 Hospital Drive, Asheville Surgical Center, and Mission Children's Hospital, among a number of other ambulatory centers is managed by this recruitment team. (Tr. 117:18-25, 118:1-15.)

Currently, there are four nurse recruiters dedicated to Buncombe County, North Carolina, covering the Employer's proposed unit. (Tr. 118:24-25, 119:1-2.) Notably, the four nurse recruiters for Buncombe County do not typically recruit for a specific job opening for any specific location or clinic. (Tr. 119:3-9). Instead, recruitment for Buncombe County is focused on building a pipeline of candidates by identifying candidates with the sort of skills that are typically useful in Mission Health's locations and clinics in Buncombe County, without regard to whether there is an open position at the time. (Tr. 119:10-24.) Recruiters then make candidates aware that they will be contacted when an opportunity becomes available. (Tr. 119:18-24.)

Additionally, candidates recruited to work at Mission Health are not even recruited specifically for one facility. (Tr. 120:4-10.) In fact, recruiters do not even speak with candidates about any specific facility. *Id.* Instead, the Employer's recruiters for Buncombe County speak to candidates about any facility or opportunity that may be of interest to a candidate. (Tr. 120:11-17.) One method used by the Buncombe County recruiting team is attendance at job fairs. (Tr. 119:25, 120:1-15.) There, the nurse recruiters are "representing" all of Mission Health, not simply one facility. *Id.*

The Employer's recruitment team for Buncombe County also works from a single applicant tracking system, which is called iCIMS. (Tr. 120:18-22.) iCIMS is used throughout Mission Health for recruiting and is the same system for all of the facilities and sites in the Employer's proposed unit. (Tr. 121:5-9.) Recruiting is a ground-up effort, and requires several layers of approval within Mission Health before any internal or external candidates will see a vacancy within Mission Health. (Tr. 121:19-25, 122:1-25, 123:1-5.)

First, a nurse resignation or other end-of-employment event at one of the Employer's facilities will prompt the hiring manager at that facility to create a requisition for that newly-formed vacancy. (Tr. 120:18-25, 121:1, 9-24.) Requisitions are built by providing information similar to the status of the individual that is leaving the hospital (*i.e.*, if a full-time nurse is leaving, then a requisition for a full-time nurse vacancy is created). (Tr. 121:25, 122:1-7). Hiring managers build these requisitions and enter them into the Employer's centralized human resources information system, Lawson. (Tr. 120:18-25, 121:1, 19-24). Lawson then feeds any new candidate requisition though several levels of approval, until it receives a final approval, at which point it transfers to the iCIMS system, which then allows the recruiting department to begin recruiting a candidate who can fill that specific position. (Tr. 122:10-19.)

Once a requisition has gone through the appropriate approval process, the recruiting department receives the approved requisition in the iCIMS, at which point the recruiting department will open the approved requisition and post it to a single site that is visible to internal and external applicants. (Tr. 122:18-25, 123:1-5.) Once a position has been posted by the recruiting department, anyone interested in the posted position can complete an application, which is then sent to the recruiting department for consideration by the recruitment team, who are responsible for reviewing those applications. (Tr. 123:6-15.)

The application process, which feeds automatically from Lawson into iCIMS, is automatic and the same for all positions for which there is an opening in any of the Employer's facilities in the proposed unit. (Tr. 122:10-25, 123:1-15, 124:11-14). Indeed, the recruiting process is the same for staff registered nurses as it is for CRNAs and nurse practitioners. (Tr. 131:13-21.)

While qualifications for specific positions may vary based on the job opening available, the recruitment team serves as a central vetting department for the Employer, avoiding the need for individual managers to compete for candidates across facilities. (Tr. 123:16-25.) In order to determine whether a candidate is a good fit for a particular position, the recruiting team is provided with a job description for the open position, and then consults with the hiring managers for that position to ensure that the recruiting team understands what type of experience is required for that position. (Tr. 123:1-10.) This vetting process is identical across facilities within the Employer's proposed unit. (Tr. 123:11-17.)

Further demonstrating the uniformity of the recruiting process, after the recruiting department determines that a particular candidate is qualified for a position, they speak with that candidate directly on a telephone call, and determine their fitness for the position in question. (Tr. 125:19-22.) Thereafter, the recruiting department will ask the candidates for their availability to

speak with the hiring manager for the particular position on a telephone call, and, in instances where the candidate is local and/or otherwise available, will ask that person if they are available for an in-person interview with the hiring manager. (Tr. 125:23-25, 126:1-7.)

While applicants do ultimately speak directly with hiring managers directly on the phone, interviews with a hiring manager are scheduled by the recruiting department. *Id*. In fact, the recruiting department has direct access to the calendars of every facility's hiring manager through Microsoft Outlook, which allows the recruiting department to set up interviews while the candidate is on the phone with the recruiting department. (Tr. 126:8-14.)

Ultimately, the recruiting department remains fully involved in the candidate interview and hiring process, and will follow-up with the hiring managers regarding whether an offer is to be extended to a particular candidate. (Tr. 127:6-19.) When a candidate is a match, and a hiring manager wants to extend an offer of employment, the recruiting department develops the appropriate compensation offering for a candidate and discusses potential orientation dates with the candidate over the phone. (Tr. 127:22-25, 128:1-12.)

Job offers to candidates are first made telephonically, and if a candidate verbally accepts an offer, it is the recruiting department that will then create a formal offer letter within the Employer's iCIMS system. (Tr. 128:13-18.) Offers are then sent via the iCIMS system to candidates' e-mail addresses, which are on file. *Id.*

The recruiting department also sets an employee's wage rates. (Tr. 128:19-25, 129:1-3). The recruiting department is trained to develop job offers for the positions for which it recruits, and autonomously creates uniform job offers based on guideline that is provided to the recruiting department from a Mission Health compensation team. *Id*. The main factor that the recruiting

department looks to when determining a candidate's compensation is the years of experience of the candidate, and not the facility for which an offer is going to be made. (Tr. 129:4-7).

Additionally, if the candidate is not qualified or does not have the appropriate credentials for the position for which he/she applied, the recruitment team frequently discusses with the candidate other positions that are available in the System. (Tr. 124:25, 125:1-12; 126:21-25, 127:1-21.) These discussion are not restricted to a particular site or facility, but instead span across all of the posted positions for all of the Employer's facilities in Buncombe County. (Tr. 126:21-25, 127:1-5.) In such situations, the recruiting team will attach a candidate's application profile to the other positions in which candidate may be interested and/or may be qualified, regardless of at which facility the position is located. (Tr. 127:6-19.)

Mission Health also has a centralized drug testing process, which is initialized during the on-boarding process as described below. Specifically, once a candidate accepts a job offer via e-mail, the recruiting department receives a notification of that acceptance, which triggers a background check of the candidate. (Tr. 129:18-24.) The Employer uses a vendor, PreCheck, to perform all of the background checks for all of the Employer's new hires, including registered nurses, regardless of facility or classification within Buncombe County. (Tr. 166:1-24.) Once the recruiting department triggers PreCheck to run a background check, and the candidate has accepted the job offer, the onboarding team begins its involvement in the hiring process. (Tr. 130:11-19; 149:21-25, 150:1-25.)

(b) Onboarding is the same.

For all of the registered nurses in the Employer's proposed unit, the entire onboarding process is performed by the Employer's People Operations department located at 1 Hospital Drive. (Tr. 149:10-20.) This includes onboarding for all nurses within Buncombe County. (Tr. 150:13-22.)

After the recruiting department triggers a background check and the candidate has accepted the job offer, recruiters are paired up with an onboarding specialist, who in turn is assigned the new hire. (Tr. 150:23-25, 151:1-9.) The onboarding specialist then begins the process of onboarding the new hires and assists the new hire until the first day of employment. *Id.*

First, the onboarding department sends new hires a welcome email, letting them know what to expect during the onboarding process. (Tr. 151:12-23.) This email also contains a link so that new hires can log-on and complete a number of onboarding tasks that must be finished prior to the start of their employment. (Tr. 151:12-23.) These tasks are sent to all new hires, including registered nurses, regardless of whether that new nurse is a staff RN, CRNA, or any other kind of nurse. (Tr. 151:24-25, 152:1-15; Er. Ex. 10.) The same task list and forms are sent to all new employees to complete. (Tr. 151:24-25,152:1-15,154:4-7; Er. Ex. 10.)

Once a background check has been completed, the onboarding department reviews it to confirm that the information therein is compliant with the Employer's standards. (Tr. 165:12-25.) If a background check reveals that a new hire has had a criminal conviction, the Employer's Director of People Operations, Lori Halula, will generally evaluate that individual's history to make a determination as to whether the Employer will move forward with hiring that individual. (Tr. 168:14-21.) Additionally, the onboarding department sends the new hire an email through PreCheck requesting that the new hire complete section 1 of the Form I-9. (Tr. 165:12-25, 166:4-9).

In addition to a background check, the Employer verifies new hires' employment history, including dates of employment and positions held. (Tr. 168:22-25, 169:1-17.) If the background check and employment verification are satisfactory, the Employer sends an email to the individual congratulating them on having completed his/her background check. (Tr. 169:18-24.) This email

also informs new hire that they are required to contact "WorkWell" and schedule their health assessment appointment. *Id.*

WorkWell is the Employer's department that performs the health assessments of all new hires. (Tr. 169:25, 170:1-6.) WorkWell ensures that new hires have proper immunizations, conducts drug tests, and generally reviews new hires' health history to make sure that they are able to begin work. *Id.* WorkWell's primary location is at 2 Medical Park Drive and this is where the majority of new-hire assessments are performed. (Tr. 170:7-21.) WorkWell also has several satellite locations that new hires are able to utilize. *Id.* Notwithstanding location, all of Mission Health's new employees in Buncombe County are required to utilize WorkWell for their onboarding screening. (Tr. 170:22-25, 171:1.) WorkWell and the onboarding department participate in a conference call the Friday before a given orientation to determine if any employee is not eligible to participate in orientation and begin employment because she failed to successfully complete the new-hire assessment. This applies to all new hires throughout Mission Health. *Id.*

Mission Health's consistent practices also extend to its requirements and procedures for new hires to obtain ID badges, and all new hires are required to obtain these badges prior to working at any of Mission Health's locations. (Tr. 172:16-18; Er. Ex. 10.) In order to obtain an ID badge, new hires upload a photograph directly on Mission Health's onboarding portal if certain criteria are met. (Tr. 172:19-25.) Mission Health's badge office then reviews the uploaded photo and determines whether the photo satisfies the badging requirements. (Tr. 173:1-8.) If the photo is unacceptable, Mission Health's badge office notifies the employee of such, and directs the employee to Mission Health's badge office located at 520 Biltmore Road to have their picture taken. *Id.* Most new hires go to Mission Health's badge office to have their picture taken. (Tr.

172:19-25). The badge office then delivers the ID badges to new employees on the first day of orientation. (Tr. 173:9-13.)

(c) Orientation is the same.

Much like its new-hire process, Mission Health's orientation is fully integrated and applicable to all employees, regardless of facility or whether they work for MH Manager, MH Asheville, or MH Multispecialty Providers working in the Mission Health system in Buncombe County.

Orientation sessions are held on a bi-weekly basis, every other Monday, and approximately 80 to 130 new hires attend each orientation session. (Tr. 187:3-9.) Orientation sessions are held at 1 Hospital Drive, on either the 5th floor or the 6th floor, depending the number of attendees. (Tr. 187:10-17.) Due to the COVID-19 pandemic, however, recent orientation sessions have been conducted virtually. *Id.*

The onboarding department participates in the first day of orientation, handling certain preparation and registration tasks. (Tr. 173:14-25, 174:1-9.) First, the department creates a sign-in sheet to track those present at orientation. *Id.* When new employees arrive, the onboarding department greets them and requests that they sign-in, so that Mission Health has a record of attendance. *Id.* Further, the department will remind employees about any outstanding onboarding documents and verifies that the employee is attending the correct orientation session. *Id.*

Upon arrival, all new employees are given a packet containing their badge, a letter explaining how to log in to Mission Health's computer system for the first time, and a six-digit user ID that the employee uses to access computers contained in the Mission Health system. (Tr. 210:3-16.) Once orientation begins for the day, the onboarding department does not have any further involvement in the actual orientation process, but begins to call any no-shows to ask about their whereabouts and to make any necessary adjustments with regard to their start date or hire

status. (Tr. 173:14-25, 174:1-14.) The Human Resources team remains at orientation throughout the day, and is responsible for breaking down the room at the conclusion of the day. (Tr. 189:16-23.)

There is a written agenda for the first day orientation, which is prepared by the new employee orientation committee, with the assistance of Mission Health's Human Resources department. (Tr. 190:8-16; Er. Ex. 11). Orientation covers a number of different topics, from the rudimentary, such as the location of the bathrooms and the day's agenda, to the more central, including Mission Health's culture, mission, and values. (Tr. 190:6-23, 194:3-21; Er. Ex. 11.)

After hearing from several speakers, including Mission Health's CEO, the employees are divided into two groups; clinical and non-clinical, again without regard to their facility or whether they were hired by MH Manager, MH Ash…..etc.. (Tr. 190:24-25, 191:1-25, 192:1; Er. Ex. 11.) This is referred to as the breakout session. *Id.* The clinical group is comprised of all nurses and nursing support staff, including, for example, registered nurses who are going to work at Mission Main, a registered nurse hired to work for PSG, CRNAs, and nurse practitioners. (Tr. 192:21-25, 193:1-14.) While CRNAs and nurse practitioners breakout with nurses, physicians, on the other hand, attend the non-clinical session because they are neither nurses nor nursing support. (Tr. 193:18-22.)

Orientation also provides information about Mission Heath's policies and procedures, as well as how to access those policies on Mission Health's intranet through a program called Compliance 360. (Tr. 186:7-25, 187:1-2.) All of the policies discussed at orientation, as well as those located on Compliance 360, are applicable to all employees in the Mission Health system within Buncombe County. *Id.* All new hires are required to attend orientation at the start of their employment, regardless of job classification or work location. (Tr. 187:18-25.) Accordingly, all

new hires receive the same general training during orientation. *Id.* For example, all registered nurses who work at facilities in the Employer's proposed unit are required to attend the same general orientation. (Tr. 188:4-22.)

iii. Benefits are the Same for All Nurses.

The Employer offers all nurses the same benefits package, regardless of whether they are staff registered nurses, CRNA, or nurse practitioners, and regardless of work location or facility. (Tr. 131:13-23). Mission Health provides benefits such as medical, dental, and vision plans for all nursing positions. (Tr. 132:12-17). The length of time for employees to enroll in benefits is also the same for every nurse, regardless of work location, facility, or job classification. (Tr. 162:22-25, 163:1-4)

During the interview process, candidates commonly ask the recruiting department questions regarding benefits that Mission Health provides. (Tr. 130:20-23.) The recruiting department provides all candidates with information regarding what benefits are offered by Mission Health, regardless of facility at which the candidate may work. (Tr. 130:24-131:12). Candidates with questions are provided with an outline of the benefits that Mission Health provides, known as "Benefits At A Glance." (Tr. 130:24-25, 131:1-3). Moreover, employees who transfer within the Mission Health system retain their benefit eligibility across work locations and facilities. (Tr. 1298:17-24.)

iv. Training is the Same for All Nurses.

(a) Clinical orientation is centralized.

Every new hire, regardless of work location, facility, or position, participates in orientation, as described above. (Tr. 174:17-22). In addition to that orientation, all nurses are required complete an additional day of nursing orientation called "New Employee Orientation Day 2." (Tr. 174:23-25, 175:1-4, 189:3-6). Notably, employees who transfer from one of Mission Health's facilities to

another do not have to attend the first day of orientation again because they have already completed that orientation. (Tr. 175:5-9).

(b) Annual clinical training is the same.

All nurses at Mission Health receive clinical bundles that are assigned by the Nursing Education Department, located on the Mission Main Campus. (Tr. 1011:22-25, 1012:1-8.) This training is assigned and completed annually. *Id.* Further, the Employer maintains modules on an online learning platform called "HealthStream." (Tr. 622:15-25, 623:1-5, 1121:19-25, 1122:1-5.) Any topic of education that is deemed appropriate for a nurse to complete can be located on HealthStream by all Mission Health nurses. (Tr. 1122:15-25, 1123:1-12.) There are also annual competencies that all nurses must complete. *Id.*

(c) New leader training is the same.

New leader training is discussed in depth, below, in Section IV.B.3.e.ix.

v. Internal Transfers are Centralized.

Nurses wishing to transfer from one location to another do so seamlessly. For example, a nurse from Mission Main who applies for an open position at CarePartners Home Health Care and is selected, does not arrive at the new facility as a true new hire. Rather, she is oriented to the new work space but is otherwise treated as an incumbent employee, as described below in Section IV.B.3.e.iii. (Tr. 1071:25, 1072:1-25, 1073:1.)[7]

vi. Human Resources Functions are Centralized.

As discussed above, Mission Health maintains a centralized human resources information system called Lawson. (Tr. 94:2-9.) Lawson houses all information for each employee in the

[7] Further, any active discipline follows the transferring nurse. See Section (vi)(b) "The personnel file and discipline follow an employee," below.

Employer's proposed unit, including the names, work locations, department, job title, compensation, and home address for each employee. *Id*.

In addition to serving as the central human resources system, Lawson is the repository for vacant/open positions. The hiring manager knows whether a candidate is internal or external, and Mission Health asks managers to consider all internal candidates, provided the employee meets the qualifications of the position. (Tr. 585:7-22.) Moreover, the Employer's Human Resources functions are centralized, as discussed below, which further establishes that the excluded nurses do not have a distinct community of interest from those nurses in the Employer's proposed unit.

(a) Employees do not lose their seniority (hire) date upon transfer.

Employees who request and are granted a transfer to another Mission Health facility within Buncombe County retain their original hire date. (Tr. 587:4-11, 1298:6-24.) Thus, an employee's tenure transfers with them to the new Mission Health facility. *Id*. Mission Health simply notes the transfer in its system; the original date of hire never changes. *Id.*

(b) The personnel file and discipline follow an employee.

Similarly, as Mission Health's human resources functions are centralized, the information contained in an employee's personnel file "transfers" with the employee. Moreover, employees do not "start over" with regard to discipline or attendance. Rather, any corrective action that an employee may have accrued at the time of transfer remains intact. (Tr. 587:16-25, 588:1-3). For example, if an employee had already received a verbal warning prior to transferring, that employee's first infraction at the new location would result in the second level of discipline (not the first). (Tr. 204:6-25, 205:1-25, 206:1-4.) Likewise, attendance points continue to accrue as if no transfer had occurred, and the electronic human resources' file stays the same. *Id.* Any

departmental file is provided to the transferring employee's new manager in Buncombe County. *Id.*

(c) Employee benefits remain intact upon transfer.

When an employee transfers within the Mission Health system, the employee's benefits remain the same and there is no new waiting period before benefits can be accessed. (Tr. 587:3-11.) Similarly, the employee's PTO accrual remains the same. *Id.*

(d) There is no general orientation required upon transfer.

Employees transferring within Mission Health are not required to attend a new general orientation because, regardless of their initial location or employer, they would have already attended this orientation when they first began working for Mission Health. (Tr. 586:17-25.) *See* Section iv.a. above.

(e) The transfer notice period can be adjusted.

Usually when an employee is transferring, Mission Health requests 30 days' notice be given to the managers of the department and facility from which the employee is leaving. (Tr. 586:9-16.) The amount of notice required is not strict, however, and can be negotiated between the two managers, depending on the needs of their respective units (*i.e.*, if one manager requires the employee to stay longer, or if one manager requires the employee to transfer sooner, that can be arranged). *Id.* This fluidity with respect to the employee's transfer date is not possible with external candidates, as a Mission Health manager cannot negotiate a mutually-agreeable start date with an outside company. *Id.*

(f) Internal reference checks are performed.

While Mission Health verifies employment history of external candidates, only internal candidates are subjected to references checks whereby the hiring manager calls the employee's

current manager and asks questions about the employee's performance. (Tr. 585:16-21.) Hiring managers do not call outside companies about performance issues and instead only verify employment only. *Id.* In addition to this informal, internal reference check, Mission Health restricts internal transfers: employees may only transfer if they have been in their current role for at least six months, and employees have no active discipline (defined as discipline within the last 12 months) of a written warning or higher. (Tr. 201:9-20, 202:18-21, 203:25, 204:1-5, 205:1-11, 585:22-25, 586:1-4). If an employee with a lower level of discipline transfer, her discipline follows her. See section vi.b, "The personnel file and discipline follow an employee," above.

vii. Discipline and Discharge Are Centralized.

(a) Approval for discipline and discharge is centralized.

Further demonstrating the interrelation of the Employer's operations is that the evidence adduced at the hearing demonstrates that the Employer maintains a uniform discipline standard throughout its System. Mission Health utilizes progressive discipline in which there are various levels of corrective action, depending on the offense, unless a particularly egregious action necessitates skipping steps in the progressive discipline chain. (Tr. 198:4-9, 208:4-12.) Before such measure can be taken, however, a manager is required to consult with their assigned HR Business Partner to ensure that the requested action follows Mission Health's policies and the required documentation is completed. (Tr. 196:4-16; Er. Ex. 12.) HR Business Partners provide assistance in preparing or completing a "SBAR" form, and do so frequently in situations involving employee-investigations or when leadership has requested assurances that a particular policy is interpreted and applied uniformly throughout the Mission Health system in Buncombe County. (Tr. 200:5-17; Er. Ex. 12.)

Upon completion, the HR Business Partner or the unit or department leader submits the SBAR form to a senior leader for review and approval. (Tr. 200:18-21.) In order to ensure uniformity of policies throughout the Mission Health system, Sheila Meadows, the Regional Vice President of Human Resources is responsible for reviewing and approving all final warnings and termination decisions, regardless of the position or facility in which the individual works. (Tr. 198:17-25, 199:1-19) For example, Ms. Meadows reviews the SBAR and approves termination recommendations in the following examples: a nurse working at Mission Main; a registered nurse working at Asheville Surgery Center; a nurse practitioner working in one of the PSG clinics; and a registered nurse working in Asheville Cardiology Associates. (Tr. 198:25, 199:1-19.)

Once an SBAR has been reviewed by Ms. Meadows and the appropriate senior leadership, approval of the termination is communicated via e-mail to any applicable HR Business Partner and leadership involved in the employment action. (Tr. 200:18-25, 201:1-2.) This is how these individuals know that they have approval to move forward with that termination or final warning. *Id.*

(b) Discipline is stored centrally.

Mission Health maintains a central "corrective action inbox," which is an electronic human resources record in which all disciplinary actions are stored. (Tr. 203:3-11.) When a leader administers disciplinary action to an employee, the leader sends an e-mail with that corrective action to the corrective action inbox, which is then uploaded by a member of the Human Resources team into that particular employee's electronic human resources record. (Tr. 203:12-18.) The electronic record shows the reason for the disciplinary action, the level of the action, and the date that the action was delivered. *Id.* As stated above, that record of discipline follows the employee throughout the Mission Health system.

(c) Active discipline precludes transfer.

Mission Health's Human Resources team has access to all employees' electronic records, which is important because employees with an active written warning (*i.e.*, the second level of progressive discipline) or higher are prohibited from transferring positions within the Mission Health system. (Tr. 204:6-16). Written warnings remain "active" for a 12-month period, and stay on an employee's electronic human resources record so long as they work for Mission Health, regardless of whether an employee transfers between facilities or departments. (Tr. 205:1-14.)

This policy prevents an individual who has previously worked for Mission Health to apply for reemployment somewhere else within Mission Health in Buncombe County if that employee had received a written warning or higher within 12 months prior to the date of application. (Tr. 203:3-25, 204:1-5). In fact, the recruiting team has access to employees' electronic human resources records and will not send a candidate to a hiring manager for interview if the candidate has active discipline. *Id.*

viii. Mission Health's Compensation Plan/Process is Centralized.

(a) Mission Health has system-wide pay scales.

The recruiting department is responsible for developing job offers for the positions for which it recruits, and creates uniform job offers based on guidelines that are provided to the recruiters from a system-wide compensation team. (Tr. 128:19-25, 129:1-3). Based on those guidelines, the recruiting department sets the initial wage rate for a particular candidate. *Id.* The main factor that the recruiting department looks to when determining a candidate's compensation is the candidate's years of experience, not the facility for which an offer is going to be made. (Tr. 129: 4-7). Certification differentials are also taken into account with regard to a candidate's initial wage rate. (Tr. 136:17-22.) Regardless of experience, however, candidates can either be

compensated with a salary or at hourly rate based on the specific position being filled. (Tr. 132:18-25, 133:1-7.)

(b) Hours are aggregated for overtime purposes.

The Employer's centralized payroll system (discussed below) allows nurses to "float" to other departments or facilities within Mission Health. (Tr. 683:13-14.) In the instance where a nurse works 42 hours in a workweek by floating between two different locations, as more fully explained below, that nurse would be entitled to 2 hours of overtime, which would paid in a single check. (Tr. 686:13-21.) For example, if a nurse from a PSG clinic worked 30 hours at their normal location, and then floated and picked up a 12-hour shift at the Hope Women's Center, that individual would be entitled to two hours of overtime in that pay period. *Id.* This is also true when nurses from Mission Main work shifts at CarePartners that bring them over 40 hours in the aggregate, as well as when a nurse from Mission Main works 36 hours and then picks up an eight-hour shift at ASH, bringing that nurse to 44 hours total. (Tr. 541:7-13, 1283:18-25, 1284:1-13.) If a nurse who works 40 hours for Hospice Home Care at CarePartners picks up at shift Mission Main, that nurse is automatically put into overtime status for those hours at Mission Main that were over 40 hours in a workweek. (Tr. 1245:12-16.) Thus, the evidence demonstrates that hours are aggregated for overtime purposes when an employee works in two locations or facilities within Mission Health. (Tr. 583:3-25, 584: 1-8.)

(c) Hours are aggregated for benefits purposes.

Significantly, when a nurse works in two locations or facilities within Mission Health that nurse has his/her hours aggregated for purposes of benefit eligibility, including eligibility under the Family and Medical Leave Act. *Id.* For example, if a nurse works 20 hours at ASH and works another 10-12 hours at Mission Main, those hours are aggregated and allow the nurse to a higher benefit status (full time) and its corresponding reduced premiums. *Id.*

(d) There are system-wide non-merit pay increases.

Additionally, nurses across the Employer's proposed unit receive the same periodic pay increases, which typically occur in the late spring or early summer. (Tr. 687:9-16.) Most recently, in June of last year, Mission Health provided a non-merit pay increase of a set percentage number (*i.e.*, 2%) for all nurses within the Mission Health system, regardless of where they worked in Buncombe County. (Tr. 687:17-25, 688:1.) Importantly, nurse practitioners and CRNAs each received the same 2% pay increase as did the other nurses, while doctors did not receive that increase because their compensation is viewed differently than that of nurses, including nurse practitioners and CRNAs. (Tr. 688:2-10.)

ix. Payroll and Accounting are Centralized.

(a) There is one payroll system at a central office.

Mission Health maintains a single centralized payroll department for all of its employees in Buncombe County. (TR 686:24-25, 687:1-8). Accordingly, as set forth above, nurses are only issued one paycheck, regardless of whether that employee floats from one location or facility to another in a given week. (Tr. 686:13-25, 687:1-4.)

(b) There is one accounting system.

Mission Health maintains a centralized accounting system. (Tr. 687:5-8.) At the start of employment, an employee signs an internal "I-form," which allows the Employer to make appropriate payroll deductions. (Tr. 157:6-15; Er. Ex. 10.) For example, employees can use this payroll deduction feature for any cafeteria purchase anywhere in the Mission Health system, regardless of the facility at which the employee works or at which facility the employee is making a purchase. (Tr. 157:16-25, 158:1-6, 943:8-25, 944:1-6.) Moreover, when an employee uses their

badge to make a payroll deduction at the cafeteria, the employee receives a discount regardless of where the employee is based. *Id.*

e. Functional Integration.

In *Stormont-Vail*, the employer had a health connections department consisting of 25 registered nurses who provided a 24/7 telephone bank accessible to all patients of all departments and units and assessed the patient needs and provided information and direction. 340 NLRB at *1209. The Board in *Stormont-Vail* cited this department as "further evidence of integration" among the Employer's facilities. *Id*. at *1209.

In this matter, the unrebutted evidence demonstrates a high degree of functional integration such that this factor militates heavily in favor of a multi-facility unit. Significantly, this functional integration further evidences the interrelation of Mission Health's operations, establishing the excluded nurses do not have a distinct community of interest.

i. Registered nurses float/work at other locations throughout Mission Health.[8]

The undisputed evidence demonstrates that RNs float to pick up work and/or routinely perform duties all across Mission Health's facilities in Buncombe County, including to and from Mission Main, as well as other facilities.

(a) Nurse interaction at the Cancer Center ("SECU").

Registered nurses working at the Cancer Center float to Mission Main to work available shifts; they also go there to perform inpatient care and provide treatment for Cancer Center patients

[8] Attached hereto as Composite Appendix B is (1) an Employee Interchange Chart illustrating the other locations at which the Employer's employees work in addition to their primary work location, and (2) a Route Map that provides a visualization for each corresponding number in the Employee Interchange Chart. The information contained therein does not constitute "new" evidence; rather Composite Appendix B is a summary of testimony and information admitted into the record evidence by the Hearing Officer, references to which are included in the Employee Interchange Chart. Accordingly, Composite Appendix B is not independent evidence and should be considered by the Region as argument. *See* fn. 3.

within Mission Main on the weekends when the Cancer Center is closed. (Tr. 489:14-25, 490:1-21.) When a Cancer Center RN works at Mission Main, that nurse works in the same location as Mission Main's RNs and, if the need arises, works hand-in-hand with those nurses. (Tr. 490:21-25, 491:1-5.) When floating to Mission Main, Cancer Center nurses are treated like any other nurse working at Mission Main, and perform the same work, in the same environment, and with the same equipment. (Tr. 488:19-25, 489:1-13)

Similarly, nurses from Mission Main will float to the Cancer Center to pick up extra hours when the Cancer Center is short-staffed. (Tr. 468:20-25, 469:1-3.) In fact, a nurse on Mission Main's sedation team regularly floats to SECU to fill-in during these times. (Tr. 1034:10-22.) Over the last couple of years, numerous nurses from Mission Main have come to the Cancer Center to perform their chemotherapy check-off, as well as pick up extra shifts. (Tr. 482:17-25, 483:1-2.) As one example, Mission Main RN Kim Hitts works at least two to three shifts at the Cancer Center during every six-week schedule. *Id.*

In addition to Mission Main, Cancer Care RNs have floated to ASH to provide coverage at that facility, as well as to provide chemotherapy treatments. (Tr. 485:1-25, 486:1-11.) Cancer Care nurses also float to Hope Women's Cancer Center, and vice versa, as well as to Mission Medical Oncology, a PSG clinic located at 21 Hospital Drive. (Tr. 485:22-25, 486:1-11, 20-25, 487:1-10.)

(b) Nurse interaction at Asheville Surgery Center ("ASC").

Asheville Surgery Center is located three miles from Mission Main. (Tr. 350:15-25; Er. Ex. 8.) Registered nurse and CRNA interchange with other facilities is rampant at Asheville Surgery Center and is based on patient access, new technologies, and patient need/ comorbidity. (Tr. 390:18-15, 391:1-7.) The interchange of these nurses flows both to and from Asheville Surgery Center.

First, it is undisputed that nurses from Mission Main perform procedures at Asheville Surgery Center. (Tr. 356:22-25, 357:1-2.)) Indeed, the Director of Asheville Surgery Center often calls Mission Main to request additional help. (Tr. 1217:4-13). Mission Main nurses also work on procedures at Asheville Surgery Center as a means to learn and gain experience in performing procedures that are set to be performed at Mission Main in the future. (Tr. 357:3-7.) An example of this type of learning opportunity is a retina procedure, wherein the Asheville Surgery Center circulating nurse will ensure that the Mission Main CRNA understands how to perform the duties associated with the procedure, as well as the expectations for after-care. (Tr. 357:8-24.)

Second, nurses coming into Asheville Surgery Center are not limited to those from Mission Main. Nurses from other facilities within Mission Health float to Asheville Surgery Center, sometimes every day. (Tr. 359:1-6.) Another prominent example is that of CRNAs from other Mission Health facilities who come to Asheville Surgery Center to perform procedures on its pediatric patients. (Tr. 357:25, 358:1-16.) Additionally, there are two SATU nurses regularly assigned to Asheville Surgery Center. (Tr. 360:16-22, 372:11-15.) If Asheville Surgery Center needs coverage for one of those nurses, another SATU nurse will float to Asheville Surgery Center from 1 Hospital Drive. (Tr. 372:6-25, 373:1-8.) Block nurses, who are based out of 1 Hospital Drive, also come to Asheville Surgery Center to assist with procedures. (Tr. 373:9-25, 374:1-20.) Significantly, when these "outside" nurses are working at Asheville Surgery Center, they are often working on the same surgical team as nurses from Asheville Surgery Center. (Tr. 359:15-25.)

Third, and perhaps most notable, Asheville Surgery Center RNs float to other facilities to work. (Tr. 350:6-14.) These registered nurses work in Mission Main's Emergency Department, operating room, endoscopy suite, and the perianesthesia suite. (Tr. 359:1-14.) The Asheville Surgery Center nurses also float into pre-operative nurse roles daily. (Tr. 1052:15-18.) Although

they primarily float to Mission Main, they also float to other facilities in Mission Health. *Id.* Asheville Surgery Center nurses have floated in this manner for the last 15 years. (Tr. 376:19-25, 377:1-2.)

Significantly, Asheville Surgery Center deploys a circulating nurse, a pre-op or SATU nurse, a recovery nurse, a scrub nurse, a CRNA, or any combination thereof, to Mission Main for surgical procedures. (Tr. 353:24-25, 354:1-23.) For example, Asheville Surgery Center sends its team, including nurses and CRNAs, to Mission Main for certain specialized surgeries such as retina procedures. (Tr. 357:8-24.) Other surgical procedures may also be moved from Asheville Surgery Center to Mission Main, and the decision to do so is the result of a very nurse-driven process. (Tr. 355:21-25, 356:1-12.) When nurses are floated from Asheville Surgery Center to Mission Main, the Director of Asheville Surgery Center remains in contact with the charge nurse, the manager, and the director of the area in Mission Main to which the nurse has floated. (Tr. 1216:6-25.) These individuals will also reach out to the Director of Asheville Surgery Center and request nurses from Asheville Surgery Center to float to Mission Main. (Tr. 1217:4-13.)

Of particular note, the Director of Asheville Surgery Center, Kristi Hensley, testified about the significant number of ASC employees, including nurses, who work at or float to multiple facilities. Specifically, Ms. Hensley identified 24 specific employees and the locations to which they float, as follows:

- Rhonda Alexander is an RN who works in ASC's Pre-Op area. (Tr. 1217:21-23.) Ms. Alexander has floated from ASC to Mission Main and worked in the Pre-Op and PACU Departments there. (Tr. 1217:24-25, 1218:1-3.)

- Cynthia Bare is an RN who works as a registered nurse circulator in the operating room ("OR") at ASC. (Tr. 1218:4-10.) Ms. Bare has floated to Mission Main to work in its OR and Sterile Processing Department. (Tr. 1218:11-19.)
- Megan Blackley is a surgical technologist who works in the OR at ASC. (Tr. 1219:2-4.) Ms. Blackley has floated to Mission Main's OR and Sterile Processing Department, and ASC's Sterile Processing Department. (Tr. 1219:16-25, 1220:1.)
- Anasthasiya Buk is a surgical technologist who works in the OR at ASC. (Tr. 1220:2-7.) Ms. Buk has floated to Mission Main's OR and Sterile Processing Department, and ASC's Sterile Processing Department. (Tr. 1220:7-11.)
- Camille Carter is an RN who works in ASC's Pre-Op and Recovery areas. (Tr. 1220:12-16.) Ms. Carter has floated to Mission Main's Pre-Op and PACU Departments. (Tr. 1220:17-20.)
- Lisa Clark is an RN who works in the pre-op PACU area of ASC. (Tr. 1220:21-25, 1221:1.) Ms. Clark has floated to Mission Main's Pre-Op and PACU Departments, as well as the SATU Department at 1 Hospital Drive. (Tr. 1221:2-7, 22-24.)
- Jordan Davidson is a surgical technologist at ASC. (Tr. 1221:8-11.) Ms. Davidson has floated to Mission Main's OR. (Tr. 1221:12-14.)
- Melissa Harris is an RN who works at ASC. (Tr. 1221:15-18.) Ms. Harris has floated to the SATU Department at 1 Hospital Drive. (Tr. 1221:19-24.)
- Ashley Huerta is a surgical technologist at ASC. (Tr. 1221:25, 1226:1-5.) Ms. Huerta has floated to Mission Main's OR. (Tr. 1222:6-10.)

- Marla Jones is an RN who works in the pre-op area of ASC. (Tr. 1222:11-15.) Ms. Jones has floated to Mission Main's Pre-Op and PACU Departments. (Tr. 1222:16-20.)
- Denise Lindsey is an RN who recently transferred from ASC to Mission Main. (Tr. 1222:21-24, 1223:5-9.) While she worked at ASC, Ms. Lindsey floated to Mission Main's OR and Sterile Processing Department, and ASC's Sterile Processing Department. (Tr. 1222:25-4.)
- Bevin McGahey is an RN at ASC who works PRN. (Tr. 1223:10-17.) Ms. McGahey has floated to the ICU Department at Mission Main. *Id.*
- Dierdra McNeilly is an RN who works Pre and Post-Op at ASC. (Tr. 1223:18-23.) Ms. McNeilly has floated to the SATU Department at 1 Hospital Drive, Mission Main's Emergency Department, and Mission Main's K-Tower. (Tr. 1223:24-25, 1224:1-7.)
- Kathryn Moorehead is an RN who works at ASC. (Tr. 1224:9-18.) Ms. Moorehead has floated to Mission Main's OR and floated for nearly one year to Mission Main's Sterile Processing Department. *Id.*
- Linda O'Neil is an RN who works at ASC. (Tr. 1224:21-25.) Ms. O'Neil has floated to Mission Main's Pre-Op and Post-Op Departments, as well as Mission Main's CVICU. (Tr. 1225:1-4.)
- Grayson Pastis is an RN who works at ASC. (Tr. 1225:4-7.) Ms. Pastis has floated to Mission Main's Endoscopy, Pre- and Post-Op, and Pre-Op PACU Departments. (Tr. 1225:8-14.)

- Jessica Peel is a surgical technologist at ASC. (Tr. 1225:15-18.) Ms. Peel has floated to Mission Main's OR and Sterile Processing Departments, and ASC's Sterile Processing Department. (Tr. 1225:19-24.)
- Brenda Robinson is an RN who work Pre-Op and PACU at ASC. (Tr. 1225:25, 1226:1-2.) Ms. Robinson has floated to Mission Main's Pre-Op and Post-Op Departments, and to SATU at 1 Hospital Drive. (Tr. 1126:3-8.)
- Deborah Shetley is a surgical technologist at ASC. (Tr. 1226:9-12.) Ms. Shetley has floated to Mission Main's OR and Sterile Processing Departments, and ASC's Sterile Processing Department. (Tr. 1226:13-17.)
- Barry Stansell is a surgical technologist at ASC. (Tr. 1126:19-23.) Mr. Stansell has floated to Mission Main's OR and Sterile Processing Departments, and ASC's Sterile Processing Department. (Tr. 1226:24-25, 1227:1-5.)
- Dina Vasilyev is a surgical technologist at ASC. (Tr. 1227:6-11.) Ms. Vasilyev has floated to Mission Main's OR and Sterile Processing Departments, and ASC's Sterile Processing Department. (Tr. 1227:12-17.)
- Jessica Waltz is an RN at ASC. (Tr. 1227:18-21.) Ms. Walz has floated to Mission Main's Pre-Op and PACU Departments. (Tr. 1227:22-25, 1228:1.)
- Anna Whitmire is an RN at ASC. (Tr. 1228:2-6.) Ms. Whitmire has floated to Mission Main's Pre-Op and PACU Departments, and the SATU Department at 1 Hospital Drive. (Tr. 1228:7-12.)
- Jeff Bollinger is an RN at ASC. (Tr. 1229:1-3.) Mr. Bollinger has floated to Mission Main's OR Department. (Tr. 1229:4-8.)

Finally, Mission Health's perioperative health services, which provide continued care for Mission Health patients requiring surgical or procedural services, are located at Mission Main and also extend to ASC. (Tr. 379:16-20, 380:11-15, 380:23-25, 381:1-3.) Nurses in the perioperative health services department with the title "ASC Pre/Post" perform pre- and post-operative care, including preparing patients for surgery and assisting those same patients through their recovery. (Tr. 389:14-25, 390:1-7.) Nurses listed as "ASC Registered Nurse Surgery" are actually nurse circulators who work inside the operating room during surgeries. *Id.*

Like all other aspects of Mission Health, surgery is a team-based approach that requires a multi-disciplinary set of skills. (Tr. 392:10-25, 393:1). This team-based approach means that a surgical team is comprised of a CRNA, a pre-operative nurse, the anesthesiologist, the surgeon, and the circulator. (Tr. 393:4-10.) Before the circulator nurse brings the patient to the operating room, the team huddles together to have a conversation and a dialogue about the plan of care for the patient that includes a patient introduction, including the patient's name, birthday, the procedure to be performed, the patient's wishes for communicating with family members, potential comorbidities, and plan of care for when the patient returns home, all to ensure that the team is working together and is on the same page. (Tr. 393:13-20.) After this huddle, the circulating nurse and nurse anesthetist talk about the patient and then proceed into the operating room. (Tr. 393:21-25, 394:1.) During this time, the nurses are exchanging information about how to best care for the patient. *Id.*

Mission Health's surgical perioperative services take place in several locations, including at Mission Main and at other outpatient operating rooms. (Tr. 387:16-25.) The location at which a patient has surgery has to do with scheduling and doctor availability which, in turn, may require a doctor to perform separate inpatient and outpatient procedures at Mission Main and at Asheville

Surgery Center on the same day, in order to ensure the outpatient access to the doctor, and to provide the same level of service to both patients. (Tr. 388:1-25, 389:1-6.) Given this fact, registered nurses who work at perioperative services at Mission Main may also perform services at Asheville Surgery Center. (Tr. 390:8-17.) Indeed, since there is one team based on patient access, perioperative services nurses float or work between Mission Main and Asheville Surgery Center. *Id*.

For example, when there is a need for a certain skill or when a new technology is being utilized, a team member or a surgeon will ask for someone who possesses that specific skill, so that individual may go from Mission Main to Asheville Surgery Center to help with that specific skill or technology. *Id*. This floating may also result from a patient that has comorbidities that require special attention or require more acute care resources for that patient, which would require a registered nurse to float to or from Mission Main and/or Asheville Surgery Center. (Tr. 380:18-25, 391:1-7.) Registered nurses float between Mission Main and Asheville Surgery Center for reasons including: (1) patient volume at one location versus another (Tr. 391:8-17); and/or (2) seasonality as certain surgeries tend to be more common during a certain time of year (***e.g.***, hysterectomies for schoolteachers when school is out for the summer). (Tr. 391:18-25, 392:1-4.)

This constant exchange and floating shows that nurses in Mission Health's perioperative health services unit, like ASC as a whole and the rest of Employer's proposed bargaining unit, are integrated.

(c) Nurse interaction at Reuter.

Inpatient pediatric nurses float from Mission Main to Reuter to support the needs of that operation when Reuter requires nursing coverage for vacations, sick call-outs, and during periods of multiple latency. (Tr. 316:21-25, 317:1-25.) Reuter's Clinical Supervisor Amber Hyman simply

reaches out to Brittany Austin, Mission Main's Inpatient Pediatric Nurse Manager, and requests that nurses be sent to Reuter. (Tr. 312:24-25, 313:1, 316:21-25, 317:1-18.)

Further, Mission Main maintains a sedation team comprised of registered nurses who report to Ms. Austin. (Tr. 318:22-25, 319:1-13.) These nurses travel to different facilities within Mission Health to perform sedation functions required for a procedures or diagnostics. (Tr. 319:1-5, Tr. 1029:20-25, 1030:1-16; 1031:3-25, 1032:1-25, 1033:1-24.) The sedation team is regularly scheduled to work at Reuter four days per week, usually in the mornings. (Tr. 320:9-25, 321:1-6.) If the sedation team runs behind while at Reuter, either Ms. Hyman or another nurse from Reuter assists by proceeding to sedation team's the next location so that the team does not fall behind further. (Tr. 321:7-25, 322:1-2.)

While the Mission Main sedation team is at Reuter, those nurses are working side-by-side at the bedside with Reuter's nurses. (Tr. 322:13-25, 323:1-3.) Indeed, the sedation nurses stay at the bedside throughout the entire procedure working in tandem with Reuter's nurses. (Tr. 323:13-24.) By way of example, if a patient needs to be sedated for a Botox injection, the Reuter's nurse enters the room with the provider. (Tr. 323:25, 324:1-21.) Both nurses then perform their designated tasks during the procedure. *Id.*

(d) Nurse interaction at Asheville Cardiology Center ("ACA").

Nurses at Asheville Cardiology Associates (a physician practice) and Mission Main frequently interact with each other. (Tr. 240:2-21.) Likewise, nurses at Mission Health's outpatient cardiac rehabilitation service, known as Heart Path, also interact with other nurses, such as those at Asheville Cardiology Associates, on a daily basis in order to discuss patient care, medications, limitations, restrictions, and other matters regarding patient care. (Tr. 253:1-19.)

Mission Health has a Cardiovascular Testing Team, which operates at Mission Main and Asheville Cardiology Associates, as well at locations in Hendersonville and Rutherford, and whose team members are nurses. (Tr. 289:14-24.) These RNs perform the same types of procedures and function in the same roles regardless of location. (Tr. 290:6-13.) Accordingly, they work together and in alignment, while interacting with the nurses at the facility to which they have traveled. (Tr. 290:14-22.)

Additionally, nurse practitioners working at Asheville Cardiology Associates round on patients in Mission Main's inpatient heart units. (Tr. 292:15-25, 293:1-2.) Those nurse practitioners also round on patients at the Advanced Cardiac Care Clinic, which is a physician practice group located within Mission Main. *Id.* Moreover, the record is undisputed that ACA RNs regularly float to perform work at Mission Main and/or one of its outpatient facilities (HOP-Ds). (Tr. 670-683, Er. Ex. 16.) By way of example, since January 2018:

- ACA Medical Assistant Jessica Metcalf has worked at Mission Main's heart unit, as a sitter, and at its cardiovascular preventive care unit
- ACA RN Ramona Harris has worked at Mission Main's Cardiac ICU unit, Heart Data Services call center, and neuro trauma ICU unit
- ACA Nurse Practitioner Bridget Hansel has worked at Mission Main's echocardiology unit and its Cardiovascular Diagnostics department
- ACA Practice Specialist Elizabeth Rask has worked at Mission Health's education department and emergency management department and at Mission Main's food and nutrition department and doing COVID screenings at Mission Main
- ACA RN Alicen Doll has worked at Mission Main's med/surg ICU unit
- ACA RN Shelba Russell has worked at Mission CV Diagnostics

- ACA RN Casey Shehan has worked at Mission CV Diagnostics
- ACA RN Matthew Grainger has worked at Mission Main's medical telemetry observation unit, emergency department, and education department
- ACA Practice Specialist Kim Stepp has worked at Mission Main doing COVID screenings
- ACA RN Janet Sheppard has worked at Mission Main's RN administration department
- ACA Medical Assistant Cheyenne Searsey has worked at Mission Main's pediatric units

Id.

(e) Nurses interaction in Home Hospice.

Nurses who work at CarePartners' home hospice department provide care for patients in their homes. (Tr. 1236:21-23, 1238:24-25, 1239:1-4.) Often, the bulk of hospice care referrals come from Mission Main, so nurses working in CarePartners' hospice department have the ability to access information related to those patients, such as their most recent hospitalization and the appointments, diagnostics, tests, labs, and similar information. (Tr. 1242:20-25, 1243:1-19.) These hospice nurses utilize that information in order to develop an appropriate care plan and the have the ability to document information in the patient's Mission Main record regarding whatever care they provide those patients. *Id.*

The care that is provided by hospice nurses and inpatient nurses is very similar; the only difference is the location where the care is provided. (Tr. 1243:20-25, 1244:1-6.) In fact, these two positions are so similar that nurses from Mission Main have transferred to work in CarePartners' hospice department. (Tr. 1244:7-10.) Indeed, in the last six months, nurses from Mission Main's

Pediatric, Neonatal Intensive Care Unit, ICU, CDLR, and Catheterization Lab Departments have transferred from Mission Main to CarePartners' hospice unit. (Tr. 1244:11-16.)

Notably, nurses who have transferred from Mission Main to CarePartners home health still have significant flexibility and continue to pick up hours at Mission Main. (Tr. 1244:17-25, 1245:1-3.) This type of transfer is so common among the nurses in the Employer's proposed bargaining unit that those nurses have two job codes: a primary one and a secondary code, which allows for a seamless transition for people to work at the location of their choice. *Id.* Additionally, since Mission Health's facilities are fully integrated, any nurse that works more than 40 hours in a week will be paid overtime, regardless of the location at which they end up working overtime. (Tr. 1245:4-16; *See* Section IV.B.3.d.viii(b), above.). Moreover, nurses are shared throughout Mission Health. (Tr. 1245:17-19.) For example, a charge nurse can work a weekend shift at one location, such as Solace, and then also work at oncology at Mission Main. (Tr. 1245:20-25, 1246:1.)

(f) Nurse interaction at Asheville Specialty Hospital.

At ASH, nurses provide care to ill patients that require long-term hospitalization. (Tr. 1079:15-20.) In order to perform their job duties, the nurses at ASH, like all other nurses at Mission Health, assess and monitor their patients, and collaborate with the interdisciplinary team (which includes nursing, physical therapy, occupational and/or speech therapy, and respiratory therapy) to plan care for those patients. (Tr. 1079:21-25, 1080:1-6.)

As at all of the Mission Health facilities in Buncombe County, nurses who work at ASH also work at other facilities in Mission Health, including Mission Main and CarePartners. (Tr. 1087:23-25, 1088:1-3.) Indeed, the nurses who work at both ASH and Mission Main work in interventional radiology, among other areas. (Tr. 1088:4-7.) The nurses who work at both ASH

and CarePartners work in CarePartners inpatient rehabilitation facility, which is where patients go who require extensive rehabilitation therapy. (Tr. 1088:16-24.)

In addition to traveling from one facility to another in order to work, ASH nurses also accompany patients during transport, and collaborate with different departments and facilities at Mission Main to care for patients during procedures there. (Tr. 1091:15-25, 1092:1-2.) For example, if a patient is going from ASH to the radiology department located at Mission Main, the ASH nurse accompanies that patient during transport and collaborate with the radiology team to monitor and care for the patient during the procedure. (Tr. 1091:22-25, 1092:1-15.) During these collaborative efforts, the ASH nurse is responsible for monitoring the patient's safety, including monitoring vital signs while the radiology nurses from Mission Main provide radiology services. (Tr. 1092:24-25, 1093:1-8.) When needed, the ASH nurse will also assist in providing radiology services for that patient. (Tr. 1093:9-11.) This type of interaction between Mission Main and ASH nurses occurs on a daily basis, approximately four times a day. (Tr. 1093:12-19.)

There are also registered nurses who work at Mission Main but who go to ASH to assist with patient care, such as to provide chemotherapy infusion therapy at ASH rather than requiring the patient to be moved to Mission Main for that therapy. (Tr. 1088:25, 1089:1-25, 1090:1-2.) Both the Mission Main nurse and the ASH nurse are responsible for the same patient, and collaborate together to care for the patient while the infusion occurs. *Id.* Similarly, the vascular access tube team nurses from Mission Main work at ASH to prepare lines for patients. *Id.* ASH also utilizes nurses from the internal staffing agency as those nurses are familiar with the Mission Health system and function with the same nursing standards of care that are present throughout Mission Health. (Tr. 1090:25. 1091:1-14.)

ASH nurses also work with RNs at Mission Main to assess whether patients at Mission Main are ready to leave Mission Main and are good candidates for admission at ASH. (Tr. 225:7-16.) See Section IV.B.3.c, below.

(g) Nurse interaction at CarePartners rehabilitation facility.

CarePartners Rehabilitation Hospital nurses are qualified to work at other Mission Health locations and vice versa. (Tr. 1156:12-25, 1157:1-3, 1159:7-12.) For example, CarePartners' Rehabilitation Hospital's Executive Director, Mitzi Holmes, currently has employees from Mission working at her facility. (Tr. 1156:15-17, 1159:22-25.) This includes six registered nurses from Mission Main, as well as a nurse from a physician's office. (Tr. 1160:1-4.)

This is also true of other health care providers. Indeed, Ms. Holmes testified that, when ASH has needed occupational therapists to float to their facility, CarePartners rehabilitation facility has been able to provide those occupational therapists. (Tr. 1160:18-24). Even when CarePartners has not been able to share its occupational therapists with ASH, ASH has been able to obtain staffing from Mission Main. (Tr. 1160:5-17.) The rehabilitation facility also shares an outpatient therapist with Mission Main, who splits her time during the week between the two facilities. (Tr. 1161:5-9.) Significantly, this outpatient therapist was primarily shared with Mission Main because, although she had a full-time position at CarePartners, her services were not required there on a daily basis, so a position was created for her at Mission Main with the help of its leadership. (Tr. 1161:10-25, 1162:1.)

Likewise, there is a registered nurse specializing in infection prevention who works at the rehabilitation facility on the main campus of CarePartners, but who reports to the infection prevention director, Jacie Volkman, who is located at 1 Hospital Drive. (1168:18-1169:22.) Having an infection prevention specialist embedded at CarePartners is required as a condition of

being part of Mission Health, and the infection prevention service line is centralized and all rolls up to one director for the entire Mission Health system. (Tr. 1171:7-16.)

Further, in addition to the general and nursing training received at orientation, CarePartners' rehabilitation nurses share Left Ventricular Assistive Device ("LVAD") coordinator nurses with Mission Main who provide ongoing care to patients having left ventricular assistive device implantations. (Tr. 1120:21-25, 1121:1-9.) That is, there are registered nurses who work with patients at both Mission Main and CarePartners as the patient transitions from in-patient to outpatient services. (Tr. 1121:10-18.) Those same nurses provide training and education to CarePartners nurses, along with in-services that include the training on the HealthStream module, an online learning module system, explained above. (Tr. 1121:19-25, 1122:1-5.)

Nurses from Mission Main also educate the CarePartners rehabilitation nurses regarding post-assessment changes in patients, and provide any changes in a given patient's plan of care. *Id.* Importantly, Mission Main nurses continue to educate the rehabilitation nurses even when there are no LVAD patients at the rehabilitation facility so that the rehabilitation nurses are always up to date with the most current competencies to care for these patients. *Id.*

In addition to Mission Main nurses who work at CarePartners because of their patient-specific obligations, like the LVAD patient transfers, as mentioned above, there are also Mission Main nurses who simply pick up hours and shifts at CarePartners. (Tr. 1129:3-5.) In fact, there are nurses and LPNs who work in Mission Main's trauma unit, orthopedic unit, spine unit, and the clinic, as well as from CarePartners PACE facility (which is all-inclusive care for the elderly), who pick up hours and shifts at CarePartners rehabilitation facility. (Tr. 1129:6-12.) In addition to staffing nurses and LPNs from Mission Main, physical therapists, occupational therapists, certified nursing assistants, certified medical assistants, and transportation aides have all picked up hours

or shifts at CarePartners rehabilitation facility. (Tr. 1130:21-25, 1131:1.) The rehabilitation facility also uses Mission Health's internal staffing agency to fill "holes" and "gaps" in its scheduled shifts. (Tr. 1131:2-15.)

Conversely, although the rehabilitation facility has a high census and thus a limited ability to allow its nurses to work elsewhere, Ms. Holmes testified she has never rejected a request from a CarePartners nurse who wanted to work at Mission Main unless that nurse cannot be spared from her usual department. (Tr. 1160:5-17.) Otherwise, those nurses, historically, are given the opportunity to work at other locations. *Id.* Further, as with other CarePartners facilities, the rehabilitation facility utilizes liaisons who work at Mission Main to assist in patient referrals. *See* Section IV.B.3.e.xx, below.

(h) Nurse interaction at Solace.

The testimony of the clinical manager for the inpatient hospice unit at CarePartners Hospice, which is known as Solace and located at 21 Belvedere Road, further supports the conclusion that nurses across the Employer's proposed bargaining unit perform the same services and are integrated with one another.

Solace is a 27-bed unit that provides end-of-life care to patients who have elected the end-of-life hospice Medicare benefit. (Tr. 1136:3-9.) In addition to providing patient care and consolation to family, nurses at Solace also work on educating patients regarding any facility into which the patient may transfer, and will collaborate and participate in ongoing discussions with the nurses at the other facility who are going to receive the patients. (Tr. 1138:6-25, 1139:1, 1143:15-23.) Most of Solace's patients are referred from Mission Main or from CarePartners home healthcare providers. (Tr. 1136:10-21.) While Solace has 22 registered nurses who work at in-patient hospice itself, it also has transitioning case managers who are Solace nurses, but who work

at Mission Main. (Tr. 1136:22-25, 1137:1-25, 1138:1.) Those nurses, specifically, work with case managers at Mission Main, who are employed by Mission Main (Tr. 1138:2-5.)

Additionally, nurses who work at Solace have come from other Mission Health locations, including a nurse who currently works at Solace who formerly worked at Mission Main. (Tr. 1144:17-25, 1145:1-2.) To effectuate this transfer, Solace coordinated with the unit at Mission Main and agreed to maintain the nurse's authorization to work in that unit in the event one facility was busier than the other. (Tr. 1144:17-25, 1145:1-5.) The only restriction on this nurse's ability to work at both Solace and Mission Main is that this nurse is not permitted to incur overtime; this, however, is the same requirement of all Mission Health nurses. (Tr. 1145:16-25, 1146:1-7.)

Other nurses at Solace are given the same opportunity to work in another Mission Health facility or building if volumes at Solace are low, which is presently the case as a result of COVID-19 outbreak. (Tr. 1147:4-25, 1148:1-10.) Under such circumstance, nurses are allowed to "flex" off of work and take PTO for that day or work at other areas within CarePartners or at ASH. *Id.* By way of example, during the COVID-19 pandemic, RNs at Solace have gone to be "sitters" and "screeners" at the rehabilitation facility. (Tr. 1148:15-19.)

RNs from Mission Main have worked at Solace to assist patients as they transition from one facility to another, particularly when pediatric patients are involved, or when educating a Solace nurse with regard to a particular patient's health is necessary. (Tr. 1149:4-14.) Similarly, Solace nurses have also worked in Mission Main to consult with those nurses at the Hospital and to provide education. (Tr. 1149:20-25.)

Solace also has dedicated nurses who work at Mission Main to assist with patient referrals. *See* Section IV.B.3.e.xx, below.

(i) Nurse integration at the Wound Care Clinic and Hyperbaric Center.

As the Employer's unrebutted evidence demonstrates, the nurses who work in Mission Health's Wound Healing and Hyperbaric Center are located across different facilities and departments. Specifically, while the Nurse Manager for the Wound Healing and Hyperbaric Center is located at 1 Hospital Drive, the nurses reporting to him are physically spread between 1 Hospital Drive and the St. Joseph Campus and provide patient care at those locations and in Mission Main located at 509 Biltmore Avenue. (Tr. 994:20-25, 995:1-4, 996:17-23.)

Similar to the job duties of other Mission Health nurses, the wound care nurses perform the following: (i) both inpatient and outpatient assessments; (ii) planning, implementation, and evaluation of patients; (iii) oversee the delivery of patients; (iv) delegate patient care based on the patient's condition and staff availability; (v) provide direct patient care; (vi) adhere to legal, ethical, and clinical standards of care; (vii) document in an accurate and timely manner; (viii) provide individualized patient teaching; (ix) precept new staff; and (x) apply the nursing process when developing and implementing planned care for each patient. (Tr. 997:6-25, 998:1-22.)

Nearly all of the inpatient wound care nurses' patients are located at Mission Main. (Tr. 998:22-25.) Conversely, nearly all of the outpatient wound care nurses' patients are located at 1 Hospital Drive. (Tr. 999:4-11.) Additionally, outpatient wound care nurses perform wound healing services using a hyperbaric chamber (a compression chamber), which is located at the St. Joseph Campus. (Tr. 999:12-25, 1000:1-11.)

In addition to housing hyperbaric chamber treatment, wound care nurses also have their office located at the St. Joseph Campus, which includes a storage supply room where the nurses' supplies are stored. (Tr. 1001:15-25, 1002:1-3.) The inpatient wound care nurses are required to visit their office at the St. Joseph Campus every morning to start their shift, during which time

they pull the list of requisitions and patients who they are going to visit for the day, review any consults and orders that were entered overnight, and pull everything together for their day. (Tr. 1002:9-23.) After that has been pulled, the list of patients is divided among the nurses who are assigned to work that day, and the nurses go o Mission Main from there. (Tr. 1002:9-25, 1003:1-5.) Any nurse can put in a requisition (a request for a patient to be seen), including nurses at Mission Main, and that request will feed directly into a system where the wound care nurses can review it and divided it among those nurses on that shift. (Tr. 1003:17-25, 1004:1-19.)

Once a wound care nurse leaves the office at the St. Joseph Campus in the morning and heads into Mission Main to see patients, they work in several different units and can see patients throughout the entire building located at 509 Biltmore Avenue. (Tr. 1005:17-25.) During their time working at Mission Main, the inpatient wound care nurses interact with registered nurses at Mission Main. (Tr. 1006:1-5.) Specifically, those wound care nurses work with the Mission Main nurses to discuss orders, obtain patient information, clear up any vague information contained in orders, seek assistance with patients (including dressing, holding limbs, etc.), and generally to provide a second set of hands. (Tr. 1006:6-24, 1007:1-4.) Just like the floor nurses at Mission Main, the inpatient wound care nurses document the care they provide patients in Mission Health's Cerner system. (Tr. 1007:5-17.)

While these wound care nurses sometimes have access to the general medications and supplies available to nurses at Mission Main, there are instances during the course of the day where inpatient wound care nurses need to go back and forth between the St. Joseph Campus and Mission Main in order to obtain specific wound care supplies, such as dressings and items that are not typically stocked at Mission Main and more expensive specialized produces that are kept in the wound care nurses' office, where their main storage unit is located. (Tr. 1007:18-25, 1008:1-25,

1009:1-18.) Wound care nurses also return to their main office at the St. Joseph Campus in order to perform telehealth visits, in which a patient at one of the smaller facilities in Mission Health (or a nurse assigned to a patient) has a wound care concern, and the location where the patient is located does not have a certified wound ostomy nurse, so the visit is performed virtually with a camera and a robot. (Tr. 1009:19-25, 1010:1-16.)

Further evidencing the complete integration of these nurses is the fact that inpatient wound care nurses frequently fill-in for outpatient wound nurses at the ostomy clinic. (Tr. 1010:22-25, 1011:1-12.) By way of example, when an outpatient wound care ostomy nurse is sick, or there is an emergency situation, an inpatient wound nurse fills in for the outpatient nurse at 1 Hospital Drive. *Id.*

(j) Nurse floating in PSG practices.

Mission Health's PSG is comprised of several facilities, including: (1) Mission Weight Management; (2) Mission Urology; (3) Mission Wound and Healing; (4) Mission Medical Oncology; (5) Mission Regional Cervical; (6) Mission Neurology; and (7) Mission Outpatient Neuro Practice. (Tr. 1302:13-25, 1303:1-11.) PSG employs *inter alia* physicians' assistants, nurse practitioners, registered nurses, and post-op follow-up nurses. (Tr. 1303:12-24.)

PSG seeks out and hires nurse practitioners, specifically, because the nursing capacity in which those nurses have worked previously makes them well-versed to manage patients and medication, and PSG believes that those nurses are very strong clinic practitioners. (Tr. 1303:25, 1304:1-9.) Moreover, hiring registered nurses for the practices is important because, at certain times, a PSG clinic may not have another person who is trained as a nurse, which turns the facility into a "911" facility. (Tr. 1310:8-17.) Therefore, having a registered nurse on-site and ready to respond to a distress call becomes vitally important to the day-to-day operations of the practices. *Id.*

Further, PSG locations are located in places that share space with other hospital departments. (Tr. 1307:1-3.) For example, Carolina Vascular shares a clinic with Mission Main's outpatient department. (Tr. 1307:4-8.) Another example is the outpatient independent testing facility, which is a diagnostic imaging center that is also shared between PSG and Mission Main. (Tr. 1307:9-18.)

Moreover, registered nurses from one of the PSG neurology practices have regular interaction with Mission Main RNs when admitting patients into the epilepsy monitoring unit. (Tr. 1337:18-25, 1338:1-6.) When those patients are being admitted, neurology practice nurses will contact the Mission Main RNs directly, and both nurses go into the room together for the patient visit and discuss the plan of care and treatment plan. *Id*. These two nurses work together to discuss the care of the patient and any event that the patient may have that lasts over 24 hours. *Id*. Likewise, PSG nurse navigators who work in the epilepsy monitoring unit also perform daily multidisciplinary rounds during which the multidisciplinary team evaluates any new stroke patients who have been received into the unit. (Tr. 1338:11-16, 1339:12-19.) Nurses in the epilepsy monitoring unit also work together with nurses from Mission Main in the post-discharge setting if the patient was discharged from Mission Main and is seen in the clinic. (Tr. 1339:20-23.)

On occasions where clinical locations are shared between PSG and hospital outpatient department (HOP-D), it is normal for nurses to float between the HOP-D and PSG. (Tr. 1307:19-23.) For example, PSG employs an RN who also performs services at the vein clinic at 310 Long Shoals. (Tr. 1307:24-25, 1308:1-9.) Typically, that RN works on the clinic-side during the morning, and then perform pre- and post-procedures in the hospital department in the afternoon. *Id*. Similarly, there are nurse practitioners who float back and forth between Carolina Vascular,

where they work as a clinic nurse practitioner, and Mission Main, where they work rounding, discharging, and performing other duties. (Tr. 1308:17-22.)

In addition to the nurses who float between a certain PSG clinic and Mission Main or a HOP-D, there are likewise nurses who float between different PSG locations. (Tr. 1308:23-24.) When a need for a nurse at a particular practice is identified, it will typically be routed up to the attention of a manager, who will then report the shortage to a practice administrator or a market manager, who will then look across their entire portfolio of nurses and redeploy nurses to whatever practice is in need. (Tr. 1309:1-5.) This sort of nurse floating and redeployment occurs approximately every other week. (Tr. 1309:6-7.)

PSG also provides staffing support for inpatient hospital departments, and continues to do so during the current COVID-19 pandemic. (Tr. 1309:11-25, 1310:1-5.) Indeed, during the COVID-19 pandemic, PSG has worked with Mission Health facilities to determine whether staff can be redeployed to another location prior to removing nurses from its schedule. *Id*. In fact, at the time of the hearing, there were two PSG RNs who were redeployed and had been working at Mission Main for two weeks. *Id*. Moreover, prior to the pandemic, PSG nurses floated as well. For example, on occasions when there were significant weather events (*e.g.*, a snowstorm) that prevented a given PSG practice from being open, that PSG and Mission Main team up to determine if there are any needs and whether the PSG nurses can be floated to Mission Main to pick up hours/shifts instead of being removed from the PSG schedule altogether. *Id*.

RNs at PSG locations also work alongside nurses at CarePartners. For example, nurses working in PSG locations work alongside nurses at 286 Overlook Road, where Mission Health maintains both a PSG practice and PACE. (Tr. 598:20-25, 599:1-23.) Those nurses are located in the same space. (Tr. 599:24-25, 600:1-5.) Given their proximity to one another, and the open space

between the PSG clinic and PACE, the nurses at this facility regularly collaborate on the care of the patients who come into the center. (Tr. 600:6-13.)

Moreover, the interaction between the nurses employed at PACE and those employed at the PSG location extends beyond merely informal interactions and dialog, and goes as far as including meetings where both sets of RNs and nurse practitioners are present and participate in the preparation of the plan of care for all patients in their respective services at that time. (Tr. 605:14-24.) In fact, all of the nurses working in this facility are involved in the treatment plans for the patients who enter that facility. (Tr. 600:6-13.) The two sets of nurses collaborate on a daily basis if, for example, a patient at one of the units begins to exhibit poor symptoms or complains about something, at which point the PACE RNs would consult with the PSG nurse practitioners on how they should handle the concern. (Tr. 605:25, 606:1-5.)

Ultimately, the RNs and nurse practitioners at 286 Overlook Road, regardless of what Mission Health unit they specifically work for, utilize the nursing process of assessment, planning, implementation, and evaluation to provide patient care, have the same goal of curing the patients, from a nursing perspective, and work together as a single unit to achieve that goal. (Tr. 606:16-23.)

Similarly, Mission Main houses a PSG known as the Advance Cardiac Care Clinic in which registered nurses work. (Tr. 239:16-25, 240:1-10.) Not surprisingly, that practice is very integrated with Mission Main. Indeed, the nurses there may work as care team nurses for both heart failure cardiologists at the clinic and Mission Main. (Tr. 240:2-21.)

Mission Health's nurses are taught to manage the patient's care throughout the continuum, which means nurses in different departments, units, and facilities work with each other and share care information into a singular electronic medical record system, so that all of the nurses have the

most up-to-date record, information, and charts on any one patient at any given time. (Tr. 245:13-25, 246:1-16.) Therefore, if a patient comes in to a PSG location, like Asheville Cardiology Associates, and is later admitted to Mission Main, the nurse at Mission Main will be able to see what happened at Asheville Cardiology Associates. (Tr. 250:20-25, 251:1.)

Nurses in the PSG neurology practice report to Barbara Noon, Director of Ambulatory Nursing while the nurses at Asheville Cardiology Associates report to Jim Langley, as the cardiology practice's executive director, and both of them have a dotted line to report to AVP of Heart Services Mary Jackson's nursing practice at Mission Main. (Tr. 240:22-25, 241:1-7.) Accordingly, Ms. Jackson works with all of the nurses across the PSG practices at Mission Main, as well as with Asheville Cardiology Associates, to provide nurses with the proper guidelines with regard to changes in any regular nursing practice. (Tr. 241:21-25, 242:1-7.) By way of example, Ms. Jackson worked with nurses in Ashville Cardiology Associates to change the process used to treat patients with pacemakers or defibrillators from using nasal cultures to treating those individuals with antibiotic ointment. *Id*.

The nurses under Ms. Jackson's dotted-line of report generally perform the same functions, regardless of where they work, including helping the physicians see patients, calling patients to follow up with them, helping to facilitate any patient calls relative to prescriptions needed, providing test results to patients, and connecting patients with other providers to facilitate those patients' care. (Tr. 242:14-24.) To wit, nurses from Mission Main and the PSG practices generally perform the same functions and are staffed in the same manner. (Tr. 248:7-25.) In fact, as set forth above, nurses from Mission Main can go to Asheville Cardiology Associates to pick up hours and can do so as regardless of where a particular nurse is located, as they are connected to the patients through Mission Health's centralized charting system. (Tr. 248:1-21.)

(k) Lactation consultant nurses float.

All of Mission Health's lactation consultants float back and forth between the inpatient setting at Mission Main and the outpatient clinic at 2 Medical Park Drive each week. (Tr. 988:6-25, 989:1-2.) These consultants also work at the St. Joseph Campus. (Tr. 989:19-22.)

Mission Health's integration of systems and individuals provides nurses with the opportunity not only to see patients in multiple locations, but also allows them to pick up hours and shifts throughout Employer's system, without jeopardizing quality of care. Thus, this factor militates strongly in favor of a multi-facility unit.

(l) Nurse interaction at other facilities in Buncombe County.

Mission Health's functional integration is further demonstrated by the fact that nurses in Buncombe County have significant flexibility on where they pick up shifts. There are numerous examples of primary care nurse practitioners who work at Mission Health who can move between hospitals and different facilities including: (1) nurse practitioners at Vista Family Health who are allowed to pick up hours or shifts at other Mission Health locations (Tr. 651:22-25, 652:1-6.); (2) nurse practitioners at Mission Family and Internal Medicine, another primary care practice in Buncombe County, who have the ability to pick up hours and shifts at other Mission Health locations, (Tr. 652:12-25, 653:1-2.); (3) nurse practitioners at Asheville Family Medicine, another primary care practice, who can pick up hours and shifts at other Mission Health locations (Tr. 653:3-19.); and (4) nurse practitioners at Weaverville Family Medicine, another primary care practice, who can pick up hours and shifts at other Mission Health locations (Tr. 654:3-20.).

Additionally, nurse practitioners at other Mission Health practices are subject to the same human resources policies as RNs at Mission Main, and can also pick up hours and shifts at other Mission Health locations, including: (1) nurse practitioners at the MMA Neurology practice in

Asheville (Tr. 654:21-25, 655:1-12.); (2) nurse practitioners at the MMA Olson Huff, a specialty practice in Asheville (Tr. 655:13-25, 656:1-5.); (3) nurse practitioners at the MMA OP Neuro Practice, an outpatient neuro practice in Asheville (Tr. 656:6-25, 657:1-2.); and (4) nurse practitioners at Mission Infectious Disease, a PSG practice in Asheville. (Tr. 567:3-23.)

With regard to nurses picking up hours or shifts at varying locations in Buncombe County, the timecard detail for Margaret M. Horner, who is employed as an RN in the physician practice at PSA Carolina Vascular, is demonstrative of how a nurse works in multiple locations. (Tr. 661:18-24, 662:13-19; Er. Exs. 3, 14.) Indeed, Ms. Horner's time detail shows, with specificity, when Ms. Horner worked at her normal location (Carolina Vascular), and when Ms. Horner worked at another location, such as My Care Now or Mission Vein Clinic. (Tr. 662:20-25, 663:2-17, Er. Ex. 14.)

Similarly, the timecard detail report for Earl Edward Peters, who is employed as an RN at Carolina Vascular, further reflects this interaction. (Tr. 666:22-25, 667:1-5; Er. Ex. 15.) Mr. Peters is a Patient Navigator at Carolina Vascular, and his primary duty is to work with patients on their treatments. (Tr. 667:6-16.) Mr. Peters, however, has picked up hours and shifts at other locations by floating from Carolina Vascular to other locations, such as Mission Vein Clinic. (Tr. 667:17-25, 668:1-8; Er. Ex. 15.)

(m) Nurses have access to a central system to pick up shifts at different locations within Mission Health.

In conjunction with the staffing support provided by Mission Health's internal staffing agency (discussed below), staffing supervisors of individual facilities, who are responsible for the staffing of their particular facility, fill in and send out a monthly "master schedule," which shows all of the holes that have to be filled at any given Mission Health facility. (Tr. 1267:23-25, 1268:1-4). That monthly master schedule is sent to the regular staff, the PRNs, and to the internal staffing

agency, discussed below. *Id.* Staffing supervisors attempt to fill these staffing needs on a monthly basis. (Tr. 1279:22-25, 1280:1-8.) Those nurses interested respond to the needs indicated in the master schedule by stating which shifts they would like to fill. (Tr. 1279:1-9.) After a nurse responds indicating interest in filling an available slot in the master schedule, someone with editing rights to the calendar (*e.g.*, the staffing supervisor) enters that person's name directly into the master schedule to indicate the slot being occupied and no longer available. (Tr. 1279:22-25, 1280:1-8.)

In the event a shift remains open after the master schedule has been circulated to the individuals identified above, the staffing supervisor begins to reach out to individuals directly to ensure that a given Mission Health facility remains fully staffed. (Tr. 1280:18-23.) This includes reaching out directly to nurses who have previously worked at one facility and transferred to another (such as someone who previously worked at CarePartners and then transferred to Mission Main), but who remains interested in retaining a PRN position with the facility and/or interested in picking up additional shifts that are difficult to staff on a regular basis. (Tr. 1281:1-12.) Conversely, former nurses who have transferred will reach out and ask to be considered if there are any difficult slots to fill. (Tr. 1281:15-25, 1282:1-18.) These employees who work both regular nurse positions and PRN positions at different locations still wear the same uniforms, do not require any additional training for that additional shift, and are frequently limited to 4 hours shifts per week, so that they do not incur overtime. (Tr. 1283:19-25, 1284:1-7.)

ii. Mission Health has an Internal Staffing Agency.

CarePartners maintains an internal staffing agency, the purposes of which is to identify staffing needs by taking into account volume, census, leaves of absence, and any other staffing related-need. (Tr. 1289:14-20.) The staffing agency provides, among other positions, registered nurses at between 20 and 25 Mission Health locations in Buncombe County, including

CarePartners, Mission Main, WorkWell, and the PSG outpatient units. (Tr. 1288:21-25, 1289:1:11.) This internal staffing agency provides further evidence of the interrelation of Mission Health's operations.

When a request for a nurse is received by the internal staffing agency, the agency will go through a list of full-time and PRN nurses, determine those nurses' availability, and subsequently schedule those nurses to fill the request. (Tr. 1290:1-25, 1291:1-13.) The internal staffing agency has the same hiring process for these "staffing nurses" as all other nurses, which is through iCIMS described above. (Tr. 1297:16-15, 1298:1-5; See Section IV.B.3.d.(ii)(a), above) Whenever the internal staffing agency receives a request that it cannot fill with its own staff of nurses, the staffing coordinator, the director of nursing, and the scheduler of the particular area will change existing schedules so as not to have to resort to using incentive pay to fill the shift. (Tr. 1291:14-35, 1292:1-3.)

In addition to assigning its own nurse, the internal staffing agency works with nurses who are not part of the staffing agency nurse group to locate work assignments when their particular units experience a lull. (Tr. 1292:4-16.) In those instances, nurses who are scheduled to work shifts at locations where there is little demand or need are provided with notice and then floated to another unit with greater demand, such as moving a nurse from inpatient hospice to rehabilitation. (Tr. 1293:2-1293:12.)

While this process has been used for years, it has become much more prevalent given the ongoing COVID-19 issues and is based on the volume of staffing discrepancies. (Tr. 1293:13-19.) Because of the volume of staffing issues, however, the internal staffing agency is also utilizing help from redeployment teams in order to help identify which nurses are available, which nurses are being flexed, and the locations in which Mission Health has need. (Tr. 1293:20-25, 1294:1.)

This applies to the Employer's proposed bargaining unit, including ASH, Mission Main, PSG, and CarePartners, by way of example. (Tr. 1293:5-11.)

Ultimately, the overriding goal with regard to staffing nurses who are not part of the staffing agency nurse group is to make sure that those employees are able to work and do not have to utilize their PTO time. (Tr. 1296:19-25, 1297:1-9.)

iii. Nurses Seamlessly Transfer Locations in Mission Health.

As explained in Section IV.B.3.d, nurses transfer seamlessly throughout Mission Health's locations in Buncombe County, which demonstrates that Mission Health operates a highly integrated system. *Stormont-Vail Healthcare, Inc.*, 340 NLRB at 1209.

iv. Nurses Are Eligible for System-Wide Awards.

(a) Awards of Distinction**.**

Another factor the Board has found to demonstrate an integrated system is that employees throughout the system are eligible for the same awards and recognitions. *Stormont-Vail Healthcare, Inc.*, 340 NLRB at 1209. Here, all nurses in the Mission Health system, including RNs, nurse practitioners, nurse midwives, and CRNAs, can be nominated for the Awards of Distinction. (Tr. 685:5-21.) These nominations are reviewed at a local facility level, before being reviewed at higher system levels. *Id.* There are two Nursing Awards of Distinction; one for compassionate care and the other for education. (Tr. 594:9-18.) Each individual facility within the Mission Health system nominates individuals for these awards and a winner is selected from within the location. *Id.* Out of the individual facility winners, a selection committee comprised of representatives from those facilities convenes to determine the system winner. (Tr. 595:13-19.) These winners are honored at an awards ceremony at a Nursing Congress meeting, which is usually

held at Mission Main. (Tr. 595:20-25, 596:1-5.) Nurses from locations throughout Buncombe County attend the ceremony and are recognized together. *Id.*

(b) The Top 100 program.

The Top 100 Nurses program is a state-wide award program for which participants can nominate their fellow RNs. (Tr. 596:6-12.) Nominees can work anywhere in the Mission Health system, including, for example, at Asheville Surgery Center. (Tr. 596:6-12, 597:1-6.) Within the last four years, Mission Health system has nominated four to five RNs for the Top 100 Nurses, including RNs working at CarePartners and Mission Main. (Tr. 596:18-25, 597:1-3.)

(c) The Clinical Ladder.

The Clinical Ladder is an optional, clinical recognition program open to any nurse in Mission Health. (Tr. 630:24-25, 631:1-16, 634:21-25.) There are five levels in the Clinical Ladder, and there are requirements to participate at each level. *Id.* A participant will first review the criteria for each level to determine at what level to participate. *Id.* After submitting an intent to participate, the participant has 12 months to satisfy the requirements necessary to obtain that level. *Id.* At the conclusion of that time period, the participant submits a portfolio to the Clinical Ladder Committee with evidence that the requisite criteria have been satisfied. (Tr. 631:2-18.) Work location does not dictate whether an individual may participate; indeed, the Clinical Ladder Committee has received portfolios from nurses working at Mission Main, the St. Joseph Campus, Asheville Cardiology, Asheville Surgery Center, Mission Medical Oncology, and CarePartners. (Tr. 631:22-25, 632:1-19.)

(d) The Woo-Hoo Program.

Since 2013, Mission Health has contracted with a third party to supply a recognition program called "Woo-Hoo" which is available to all employees within Mission Health. (Tr. 417:21-25, 418:1-25, 419:1-25, 420:1-25.) Accordingly, all RNs, nurse practitioners, and CRNAs

use the same platform regardless of work location or facility. *Id.* Woo-Hoo allows any Mission Health employee to recognize any other Mission Health employee for something, about which other Mission Health employees are able to "like" and comment. *Id.* For example, a nurse working at Reuter can recognize the individual who delivered laundry in the morning. *Id.* The only qualifier is that the nominator and the recipient must be Mission Health employees. *Id.* Employees access Woo-Hoo through Mission Health's intranet, a specific website, or through a mobile app. *Id.* Woo-Hoo's broad nature is by design, so that team members can connect with and recognize one another throughout the entire system. *Id.*

(e) The Stand Out Program.

Since 2015, Mission Health has utilized "Stand Out," a strength-based performance management program. (Tr. 421:1-25, 422:1-25, 423:1-22.) Employees complete an assessment, which is then evaluated by the program. *Id.* The program then provides the employee with their top two strengths and information about themselves. *Id.* This data is shared with the employee's leader so that the leader can engage the employee about those strengths. *Id.* Stand Out also allows employees to provide their leaders with feedback about the work they are performing. *Id.* At least once per quarter, leaders are encouraged to send engagement polls to employees who are enrolled in the program to assess their level of engagement, areas of concern, and opportunities for improvement. *Id.* This program is available to all nurses and can be used by registered nurses, as well as nurse practitioners and CRNAs. (Tr. 421:21-25, 423:5-22.)

v. <u>Nurses Participate on System-Wide Committees.</u>

(a) The Nursing Congress.

Any nurse in Mission Health can participate in the Professional Governance Congress, which is also known as the Nursing Congress. (Tr. 632:20-25, 633:1-15.) There are monthly meetings that any RN can attend. *Id.* The Nursing Congress also has four nursing councils whose

membership comprises the voting members for the Nursing Congress. *Id.* So long as an individual is an RN at a Mission Health entity, that individual can submit an application for a voting seat. *Id.*

(b) The Fall Committee.

Mission Health has a Fall Committee for RNs who meet monthly to discuss any patients who have fallen and the injuries sustained, if any. (Tr. 474:2-18.) The members of this committee talk about how they, as nurses as a whole, can work together to prevent those falls. *Id.* Nurses from the entire system, including CarePartners, Mission Main, and all of the HOP-Ds participate on this committee. (Tr. 474:22-25, 475:1-9.)

(c) The Informatic Committee.

Mission Health has an Informatic Committee wherein nurses discuss any issues that they may encounter with the charting system that the Employer maintains on a system-wide basis. (Tr. 475:12-25, 476:1-15.) This committee is responsible for developing and implementing changes to charting assessments and medications, as well as the electronic system itself. *Id.* The nurses on this committee are from locations throughout the system. *Id.*

(d) The Quality Committee.

Mission Health maintains a Quality Committee responsible for looking at quality throughout the system and identifying any suggested changes (Tr. 476:23-25, 477:1-8.) This committee examines the system's quality metrics to determine, from a nursing perspective, any changes that should be made to safety and how the system cares for patients. *Id.* The information processed by this committee is shared system-wide by the nurses working at each location, either through a presentation at a staff meeting or through email. (Tr. 477: 9-20.)

(e) The Magnet® Committee.

Mission Main has applied for Magnet® status, which is a very distinguished honor. (Tr. 477:21-25, 478:1-14.) Working for a Magnet® hospital is something that nurses and nurse

practitioners, alike, wish to achieve. (Tr. 478:24-25, 479:1-4.) Accordingly, Mission Health maintains a committee involving nursing staff to help Mission Main to obtain Magnet® status. *Id.* The physician services groups participate in providing information, as well. (Tr. 478:14-23.)

(f) The CLABSI Committee.

The CLABSI Committee, which is comprised of nurses from throughout Mission Health, examines central line infections and identifies ways in which to prevent them. (Tr. 479:7-25, 480:1-14.) If a patient develops a central line infection, the committee is responsible for tracing the patient and possible infection cause to determine the course of care provided to that patient and ensure consistent infection precautions throughout the system. *Id.*

(g) The Pediatric Palliative Care Committee.

Mission Health maintains a Pediatric Palliative Care Committee, which is composed of nurses working in Mission Main's pediatric unit. (Tr. 472:22-25, 473:1.) This committee identifies and discusses palliative care concerns for patients and makes recommendations on practice changes. (Tr. 473:2-11.) Once a practice change has been implemented, the Pediatric Palliative Care Committee is responsible for educating pediatric nurses throughout Mission Health. *Id.*

(h) The Trauma Operations Committee.

Mission Health maintains a Trauma Operations Committee, which is a part of Mission Main's Level II trauma program. (Tr. 1156:9-25.) This committee is designed to ensure that the trauma program at Mission Main is outstanding, as well as ensure that it meets the qualifications for the Level II certification it currently maintains. *Id.* As Mission Main prepares for Level I certification in the future, this committee will help Mission Main meet the applicable regulations. *Id.* The committee meets once a month at Mission Main, and CarePartners is represented on the committee. (Tr. 1156:12-25, 1157:1-13.)

(i) The Cardiovascular Operations Committee.

Mission Health maintains a Cardiovascular Operations Committee, which is a sub-committee of the Leadership Council, which provides leadership for the complete continuum of cardiovascular care in the system. (Tr. 243:6-25, 244:1-25, 245:1-12.) Membership on this committee includes a registered nurse from Asheville Cardiology Associates. (Tr. 244:20-25, 245:1-12.)

vi. Mission Health's Laundry is Centralized.

All linen processing, distribution, and delivery for all of Mission Health's facilities is handled at a central location. (Tr. 555:21-25, 556:1-22.) Mission Health employees are responsible for picking up clean linen from the laundry plant and distributing it to the facilities within Mission Health, as well as collecting soiled laundry. (Tr. 557:16-25, 558:1.) This includes, by way of example, Asheville Surgery Center, Family Medicine Practice, Vista Family Health, and the PSG practices. (Tr. 556:23-25, 557:1-8, 1306:12-14.)

vii. Mission Health's Pharmacy is Centralized.

Mission Health maintains a centralized Pharmacy Department, which supports all pharmacy services, including the pharmacists, throughout the system. (Tr. 432:1-25, 433:1-5.) The Employer's pharmacists work in the in-patient setting, as well as at infusion centers, Asheville Surgery Center, and at other locations, with the majority of the pharmacists working at Mission Main. (Tr. 433:13-21, 434:7-12.) These pharmacists, who are all employed by MH Manager, nonetheless work in locations other than 509 Biltmore, such as Asheville Surgery Center or in an outpatient infusion area. (Tr. 433:22-25, 434:1-25, 435:1, 436:12-21.) MH Manager also employs a pharmacy technician to work at Asheville Surgery Center. (Tr. 435:2-9.) Mission Health maintains a medication distribution center at 400 Ridgefield Court which is used to stock the Pyxis medication machines. (Tr. 448:1-23.) Mission Health also maintains a retail pharmacy that is

available for use by any employee who works for Mission Health and has elected the Employer's medical insurance. (Tr. 449:3-25, 450:1-10.)

As referenced above, Mission Health's centralized Pharmacy Department utilizes Pyxis, an automated dispensing cabinet. (Tr. 437:12-25, 438:1-5.) These cabinets are located on nursing units or where patient care is provided. *Id.* When Pyxis receives a medication order through the electronic medical record program, the attending nurse logs into the device and dispenses the medication from the machines. (Tr. 437:12-25, 438:1-25.) Pyxis is used throughout Mission Main, as well as at Asheville Surgery Center. (439:18-25, 440:1-7.)

The Pharmacy Department also utilizes Pyxis to enhance visibility of its medication throughout the system. (Tr. 439:7-17.) Pyxis generates reports, which assists the Pharmacy Department to help track potential medication diversions. (Tr. 440:19-25, 441:1-25, 442:1.) The Pharmacy Department maintains a robust process to identify any potential diversion. *Id.* This process includes a review of the Pyxis reports by a pharmacy technician, as well as a review by the medication diversion team. *Id.* The medication diversion team then examines all controlled substance use in any location that reports to Mission Main, including all inpatient units and operating rooms, including Asheville Surgery Center. *Id.*

Additionally, CarePartners has a pharmacy located within the rehabilitation hospital. (1164:22-25.) While the facility has an assigned pharmacy manager during the day, CarePartners utilizes Mission Main's pharmacy for its after-hours needs and for medications it does not have in its stock. (Tr. 1165:1-8.)

viii. Mission Health's Emergency Preparedness Plans are Centralized.

The Employer maintains an Emergency Operations Plan applicable to the entire system, which is named C-360. (Tr. 515:21-25, 516:1-25, 517:1-921) This is the parent document; every

department of the each hospital and every one of the annual core practices, including all of the PSG practices, have a component part of that overarching plan, referred to as the continuity sub-plan. *Id.* All employees have access to this policy. *Id.* Emergency Management is responsible for monitoring the content of Compliance 360 and updating it on an annual basis. *Id.* While each location within Mission Health maintains its own sub-plan, Emergency Management assists these locations with support and guidance. (Tr. 517:22-25, 518:1-18.) To that end, Emergency Management developed a template plan with detailed instructions for completion and acts in a consultative capacity as departments complete their plans. *Id.* The Emergency Preparedness Department also engages with all facilities to coordinate for specific emergencies such as active shooters and natural disasters (Tr. 513:24-25, 514:1-3, 11-23.)

ix. Mission Health's Nurse Education is Centralized.

(a) Mission Health has a centralized Education Department.

Mission Health maintains a centralized education department. (Tr. 619:2-25, 620:1-14.) This centralized educational system allows Mission Health to ensure that it is providing standardized education and messaging to all of its nurses. (Tr. 625: 5-12.) To achieve this, Mission Health employs nurse educators who are registered nurses or clinical educators and provide educational assistance to each of its facilities. (Tr. 213:9-12.)

For example, there is a nurse educator who specializes in pediatrics. (Tr. 214:4-6.) This employee performs her training and educational duties for registered nurses at Mission Main, as well as at Reuter and the pediatric oncology clinic. (Tr. 214:7-25, 215:1-11.) Mission Health also employs two nurse educators who specialize in surgical services. (Tr. 215:12-18.) These nurse educators perform their training and educational duties for registered nurses in the operating rooms at Mission Main, as well as those nurses at Asheville Surgery Center and other facilities within the

system that provide surgical services. (Tr. 214:19-25, 215:1-25, 216:1-2, 622:10-14.) Mission Health employs a nurse educator who specializes in oncology. (Tr. 218:16-20.) This employee performs his job duties at the Cancer Center and the Hope Women's Center, as well as within the oncology department at Mission Main. (Tr. 218:21-25, 219:1-9.) All nurse educators meet periodically with each other, including those nurse educators responsible for providing education at CarePartners and PSG. (Tr. 219:10-24.) While nurse educators perform their job duties at various locations in Mission Health, they are employed by MH Manager, with a home work location at 1 Hospital Drive. (Tr. 217:3-25, 218:1-25, 219:1-9; Er. Ex. 3.) CarePartners has a dedicated nurse educator who is employed by MH Manager, but has a home work location at 68 Sweeten Creek Road. (Tr. 219:13-24.) PSG also has a nurse educator who is employed by MH Multispecialty Providers. (Tr. 221:3-14; Er. Ex. 4.)

(b) New nurses participate in StaRN.

In October 2019, Mission Health implemented a standard program for all new-graduate nurses called StaRN. (Tr. 628:3-18.) The program is available to all new graduate nurses within the system and involves classroom learning and a preceptorship (Tr. 628:19-25, 629:1-25, 630:1-10.) The nurses participating in StaRN engage in professional development interactions with one another regardless of work location within the system. (Tr. 630:14-23.) Employees who move from one classification within Mission Health (for example from CNA) to new grad RN also participate in the StarRN program. (Tr. 1298:25, 1299:1-6.) Moreover, even after being placed throughout the system, nurses in the StaRN program continue to interact with other nurses who were in the program for monthly meetings and projects designed to enhance their effectiveness. (Tr. 629:4-25, 630:1-24.)

(c) Nurses can participate in the clinical ladder.

As described in Section IV.B.3.e.iv(c), above, Mission Health offers its registered nurses the opportunity to participate in the clinical ladder, regardless of work location.

(d) Nurses complete preparedness training.

All Mission Health employees must complete annual training modules on natural disaster preparedness, which is completed online. (Tr. 513:24-25, 514:1-5.) This includes all RNs, nurse practitioners, and CRNAs who are employed by Mission Health. (Tr. 514:24-25, 515:1-17.) There is module for emergency preparedness each year and, at the direction of Emergency Management/Emergency Preparedness personnel, all employees of Mission Health completed the active shooter and hospital emergency response modules for 2019. (Tr. 514:11-23.)

In addition, Emergency Management provides a system-wide incident management team training program on a monthly basis. (Tr. 519:10-25, 520:1-6.) These training sessions last approximately 45 minutes and are provided through WebEx. (Tr. 520:7-10.) Many of the nursing directors attend the trainings, including those at Reuter, CarePartners, Asheville Cardiology Associates, and Asheville Surgical Center. (Tr. 520:11-25, 531:1-9.)

(e) Nurses are provided leadership training.

Mission Health employs a Director of Organizational Development whose job responsibilities include developing leaders from within Mission Health, including the system's hospitals, CarePartners, PSG, and HOP-Ds. (Tr. 408:2-25, 409:1-25.) To that end, Mission Health has created a program called Leadership Launch. (Tr. 410:1-18; Er. Ex. 13.) This program is available to anyone within Mission Health who is classified as a supervisor or above, and is a one-day course offered once per month so that the participants can learn about a topic together. *Id.* The intent of Leadership Launch is to provide supervisors with repository of information that Mission Health believes is useful for supervisors to know. (Tr. 413:3-13, Er. Ex. 13.) For example, there is

a human resources component to the course so that all leaders understand how to evaluate and correct performance, and that those methods are uniform throughout Mission Health. (Tr. 196:12-25, 197:1-25, 198:1-16.) Registered nurses who are also leaders are eligible to participate in Leadership Launch, regardless of the Mission Health facility at which they work. (Tr. 411:24-25, 412:1-25, 413:1-2.)

(f) Nurses are provided education on specific topics.

In addition to the nursing education discussed above, Mission Health has standardized education for specific procedures. For example, Mission Main performs many LVAD implants for patients who are then transferred to CarePartners rehabilitation hospital once they are out of risk of contracting infection. (Tr. 1120:25, 1121:1-9.) The patient receives treatment from an LVAD Coordinator, who are RNs working at Mission Main. (Tr. 1121:10-15.) Those same RNs also provide patient care at CarePartners. (Tr. 1121:16-18.) In addition to providing continuing care, the LVAD Coordinators also provide education to nurses at CarePartners every other month, even if there are no LVAD patients in the hospital, to ensure that those nurses are up to date with the most current competencies for these patients. (Tr. 1121:19-25, 1122:1-5, 1124:11-19.)

Similarly, Mission Health has Stroke Coordinators who are nurses employed by MH Manager. (Tr. 261:3-21; Er. Ex. 3.) These nurses partner with other nurses and physicians within Mission Main, as well as Mission Health's PSG radiology practice, CarePartners, and ASH to provide patient care. (Tr. 261:22-25, 262:1-14.)

Mission Health has a Left Atrial Appendage ("LAA") Coordinator who is a registered nurse tasked with following a patient who has undergone a left atrial appendage procedure and interacting with other nurses in the Advanced Cardiac Care Clinic and Asheville Cardiology Associates regarding that procedure. (Tr. 257:2-25, 258:1-25, 259:1-2.) The LAA Coordinator

provides a great deal of education on newer technologies and procedures for individuals at Mission Main, CarePartners, ASH, and PSG. *Id.*

Mission Health also has a STEMI Coordinator who is a registered nurse employed by MH Manager. (Tr. 260:3-25, 261:1-2; Er. Ex. 3.) The STEMI Coordinator sets up the care and partners with other colleagues for seamless care of patients who have suffered a heart attack. *Id.* The STEMI Coordinator works not only in Mission Main, but also in Asheville Cardiology Associates and CarePartners, and regularly interacts with registered nurses at those locations. *Id.*

x. Nurses Wear the Same Uniform Throughout Mission Health.

Nursing uniforms provide a visual representation of the interrelation of operation within Mission Health, providing additional evidence that the excluded nurses do not have a distinct community of interest. The standard uniform for a registered nurse working at Mission Main is a white top and navy bottom, with an employee badge visible. (Tr. 327:13:20.) A nurse has the choice to wear all white, as well. *Id.* This uniform is identical to that worn throughout Mission Health, including, Reuter's nurses as well as those nurses working in hospice and home care for CarePartners. (Tr. 327:13-20, 1236, 15-23, 1238:3-23.) Indeed, if someone were to walk into a procedure at a clinic where sedation was being used, that individual would be unable to distinguish the Mission Main sedation team nurse from the clinic-based nurse. (Tr. 326:25, 327:1-11.) This is also true of staffing nurses sent from the CarePartners staffing agency to work throughout the system. (Tr. 1299:9-15.) No matter where the staffing nurses work in Mission Health, the uniform is the same. *Id.*

xi. Nurses Use Badge Swipes for Deductions Throughout Mission Health.

As described in Section IV.B.1, above, Mission Health offers its registered nurses the opportunity to use badge swipes for meal deductions throughout Mission Health in Buncombe County.

xii. Mission Health's Marketing is Centralized.

Mission Health maintains a Marketing Department at 1 Hospital Drive. (Tr. 1240:3-10.) That central department is responsible for marketing the entire Mission Health system to the public. For example, it publishes a magazine called "My Health Life," which touts all of the facilities in Buncombe County. (Er. Ex. 22, pp 7, 10-25.) Indeed, all of the facilities use the basic Mission Health logo. (Tr. 991:12-23, 1241:4-8, 1305:25, 1306:1-2.) For example, Home Health nurses at CarePartners carry and distribute brochures created by the Mission Health marketing team, which are printed through the Mission Health print shop. (Tr. 1239:2-17.)

xiii. Mission Health Maintains a Centralized Staffing Agency.

As discussed above in Section IV.B.3.e.ii, CarePartners maintains a staffing agency, which includes registered nurses. (Tr. 1288:14-23.) This staffing agency supports between 20 and 25 locations in Mission Health, including all units at CarePartners, Mission Main, WorkWell, and some of the PSG locations. (Tr. 1289:2-17.) Currently, the staffing agency has three full time registered nurses and 17 PRN nurses. (Tr. 1289:22-25, 1290:1-6.)

Monica Renner, the Clinical Supervisor for Staffing at CarePartners utilizes this staffing agency when developing the two-week schedule for the rehabilitation hospital. (Tr. 1265:16-25, 1266:1-25, 1267:1-25, 1268:1-4.) When Ms. Renner has holes in her schedule, she emails a Google calendar with the open needs to the regular staff, PRN staff, and the staffing agency so that these individuals can pick up the open shifts. (Tr. 1279:1-8.) Ms. Renner has utilized the staffing agency

for a number of years. (Tr. 1279:10-21.) If the staffing agency is unable to fill a shift, Ms. Renner reaches out to nurses who worked at CarePartners in the past but have since transferred to Mission Main and asks them to fill in at CarePartners. (Tr. 1280:18-25, 1281:1-25, 1282:1-25, 1283:1-7.) Those nurses from other locations do not need any additional training and are able to just work the shift. (Tr. 1283:11-22.)

xiv. Mission Health Aggregates Overtime.

See Hours are aggregated for overtime purposes, Section IV.B.3.d.viii(b).

xv. Mission Health Maintains Centralized Job Descriptions.

Mission Health has a basic RN job description from which all other nursing job descriptions are built. (Tr. 1349:19-25, 1350:1-3; Er. Ex. 20.) Moreover, Mission Health maintains job descriptions for nurses who apply throughout Mission Health, including Mission Main, CarePartners, the St. Joseph Campus, and some of the home health nurses. (Tr. 1349:10-17; Er. Ex. 20.) *See* Section IV.B.3.e.xv, above.

xvi. Mission Health Maintains a Centralized Annual Nursing Report.

Mission Health publishes an Annual Nursing Report that discuses nursing on a system-wide basis and includes articles related to different facilities within Mission Health. (Er. Ex. 23.) Significantly, the Annual Nursing Report contains the Nursing Strategic Plan to guide the focus of all nurses working in Mission Health to provide excellent patient and family care. *Id.* As shown by the report itself, that Strategic Plan discusses implementation on a system-wide basis. *Id.* at p 8. This report also delves into the nursing practice for that year, nursing "wins", and nursing stories throughout Mission Health. (Tr. 1351:1-6.) Anyone in Mission Health that holds a valid nursing license receives this report, and it is circulated to all departments, including PSG and nurse practitioners. (Tr. 1351:7-18.)

xvii. Mission Main Has One License with North Carolina.

Mission Main is licensed by the State of North Carolina. (Tr. 909:10-25, 910:1-2; Er. Ex. 18.) Mission Main is licensed for 815 beds, of which 733 are general acute beds located at 509 Biltmore Avenue. *Id.* The remaining 82 beds are psychiatric or behavioral health beds, located at 428 Biltmore Avenue. *Id.* This single license also covers the number of operating rooms that Mission Main is permitted to operate. *Id.* Mission Main is licensed for 16 open heart surgery operating rooms, two C-Section operating rooms, nine ambulatory operating rooms, and 30 shared inpatient and ambulatory operating rooms. (911:8-25; Er. Ex. 18.) As set forth above, the nine ambulatory operating rooms are located at Asheville Surgery Center, located two miles away, but share a license with Mission Main. (912:1-9; Er. Exs. 8, 18.) Indeed, Asheville Surgery Center is not a separate entity from Mission Main and, therefore, is not separately licensed. (Tr. 913:2-12; Er. Ex. 19)

xviii. Mission Health Maintains a Centralized Sterile Processing Department.

Mission Main has a Sterile Processing Department that serves the main operating room, the CVOR, the women's operating room, and occasionally, the ASC operating room. (Tr. 1219:22-25, 1220:1) Indeed, Andrew Hoaglan, a registered nurse in Mission Main's operating room, has worked shifts in the Sterile Processing Department and admitted that other employees outside of that department have picked up shifts in the Sterile Processing Department. (Tr. 774:9-21.) The Sterile Processing Department at Asheville Surgery Center rolls up to the larger Sterile Processing Department at Mission Main and they work in tandem to provide services for the operating rooms.

(Tr. 1219:5-13.) Indeed, the two locations share instruments and sterile processing functions for those instruments. *Id.*

xix. Mission Health Shares Laboratory Services.

There are eight ambulatory or outpatient laboratories in Mission Health. (Tr. 54:17-25, 55:1-25, 56:1-14.) Most of these are located in Buncombe County. (Tr. 89:14-20.) All of these laboratories are blood draw stations, so that patients do not have to worry about parking at Mission Main. (Tr. 89:21-25, 90:1-4.) These services are performed by phlebotomists, who draw the blood, and medical laboratory technicians, who perform the blood analysis. (Tr. 90:5-15.) The phlebotomists and medical laboratory technicians transfer between these eight locations frequently depending on volume of a given day. (Tr. 90:16-24.)

xx. Mission Health Refers Patients to its Facilities.

Mission Health actively assists patients to move from one of its facilities to another, thereby establishing continuity of care and nurse interaction. For example, a majority of the patients seen at ASH were referred there from Mission Main. (Tr. 534:2-15.) This is also true of other CarePartners-affiliated entities. (Tr. 597:13-25, 598:1.) In fact, Solace receives many of its referrals from Mission Main as well as from ASH or from CarePartners home health. (Tr. 1106:21-25, 1107:1-18, 1136:10-21, 1242:20-25, 1243:1-9.)

These referrals are often accomplished using CarePartners nurses employed as Post-Acute Clinical Specialists, who are also known as liaisons. (Tr. 225:24-25, 226:1-10.) These nurses liaise between the case managers at Mission Main, who are also nurses, and CarePartners (including ASH) to determine whether a patient should discharge from Mission Main to ASH or one of CarePartners other facilities. (Tr. 224:18-25. 225:1-25; 226:1-17.) Post-Acute Clinical Specialists are stationed within Mission Main and meet with their CarePartners supervisors at Mission Main. *Id. (See also* (Tr. 1099:5-24, 1100:25, 1101:1-17, 1102:12-23, 1103:2-24, 1104:1-25, 1105:1-23.))

The Post-Acute Clinical Specialists have access to the patient charts at Mission Main, which is extremely helpful for these nurses to perform their assessment to determine whether someone is a candidate for ASH or another CarePartners facility. (Tr. 228:10-25, 229:1-25, 230:1-11.) They can do so as a function of working for Mission Health. *Id.*

In furtherance of these interactions, CarePartners provides daily reports to Mission Main about the admissions and discharges at the Rehabilitation Hospital and ASH, as well as projections for the next day. (Tr. 230:1-25, 231:1-25, 232:1-25, 1167:3-25, 1168:1-2) This information is communicated at a daily Safety Huddle in a conference room at Mission Main that occurs each morning at 8:30, as well by email at the end of the day. *Id.* This information is very helpful to the directors and administrators at Mission Main so that they can understand who has availability to accept patients needing to be discharged from Mission Main but who are not yet ready to function without some sort of care. *Id.*

For example, once a potential referral has been identified, ASH nurses meet with the patient, and work together with the attending nurse case manager at Mission Main, while collaborating with the physician, to review all of the patient's charts and make sure the patient meets all of the criteria to be admitted into a post-acute facility such as ASH. (Tr. 225:17-23, 228:2-5.) The attending nurse case managers are located at the actual acute hospital in Mission Main, and not at one of the post-acute CarePartners locations. (Tr. 226:5-13.) Moreover, in order to work with the attending nurse case managers and the physicians, ASH nurses are stationed at Mission Main. (Tr. 226:14-16.) Additionally, ASH nurses also walk around the acute unit at Mission Main and stop by the patients' rooms in order to hear the attending nurse care manager, the physician, and the therapist speak, in order to begin learning about the patients they are assessing. (Tr. 227:1-12.)

In addition to working closely with the nurses at Mission Main, ASH nurses also review and work on the computer-generated reports showing the medical history of the Mission Main patients to determine who may be a candidate for post-acute care. (Tr. 228:10-24.) Since ASH nurses work in Mission Main, and are considered part of Mission Health, they are able to obtain more specific details on a particular patient and review his/her actual charts. (Tr. 228:25-229:1-11.) Likewise, ASH nurses are allowed to document on patient charts at Mission Main, even before a patient has been referred to ASH. (Tr. 229:20-25, 230:1-18.) As described above, an ASH representative attends a daily "Safety Huddle," wherein any daily needs, wants, happenings, schedules, transfers, bed availability, and any other important matters at Mission Main are discussed, further evidencing the integration between ASH's nurses and those at Mission Main.

Further highlighting the level of integration of functions are the job duties of Post-Acute Transition Specialists Kyla Boyles, Marketing Director for Home Health and Hospice for CarePartners is responsible for growing and maintaining referrals for those departments, as well as facilitating and providing resources for transfers from major hospital systems. (Tr. 1098:24-25, 1099:1-4.) Although Ms. Boyles specializes in growing Solace, Ms. Boyles has four full-time nurses that report to her, as well as a PRN. (Tr. 1199:5-17, 1100:12-25, 1101:1-4.) Importantly, two of the full-time nurses that report to Ms. Boyles, who work as Post-Acute Transition Specialists, are physically located at Mission Main. (Tr. 1101:5-9, 1102:12-19.) Indeed, these nurses report to Mission Main in the morning to start their shift, meet with Ms. Boyle at Mission Main, and perform their work duties at Mission Main, unless they are called out to work at CarePartners. (Tr. 1101:10-17.)

Often, Ms. Boyles will go to Mission Main, at which time she meets with those nurses that report to her. (Tr. 1102:8-11.) As Post-Acute Transition Specialists, these nurses provide

assessments at Mission Main and assist in the transition patients to inpatient and home hospice care. (Tr. 1102:20-23.) Similarly, the two full-time nurses that report to Ms. Boyles at CarePartners provide outpatient services for long-term care to PSG and assisted living units, as well as working with home health patients. (Tr. 1103:2-6.) It is undisputed that all four of these nurses have similar functions. *Id.*

In providing home health services, CarePartners nurses go into the community to assess and transition patients for long-term care, assisted living, and physician practice to home services. (Tr. 1103:7-11.) After CarePartners receives a referral for either Solace or hospice home care, the nurses team up with the care manager, including the floor nurses, and the referring physician or provider to discuss several factors for the provision of care. (Tr. 1103:12-24.) This includes an assessment of their roles of care, the patient's family situation if a given patient's family has decided to not resuscitate the patient and, if a patient is going to back to their home, whether the patient any durable medical equipment at the home; whether the nurses need to arrange such equipment, and with whom the patient is going home. *Id.* If the patient will receive inpatient care, meaning that the patient is going to be transitioned to the general inpatient side at Solace, the nurses meet the patient and ensure that the patient meets the end-of-life criteria. *Id.*

Prior to meeting with a patient, the CarePartners nurses speak with the floor nurse at Mission Main responsible for overseeing the patient at that time for the purpose of obtaining the most up-to-date information regarding patient's appetite, whether the patient has eaten anything that day, how the patient slept the prior night, whether the patient's pain medication has increased, and any other day-to-day factors to determine whether the patient meets the Solace's eligibility criteria. (Tr. 1103:25, 1104:1-9.) Additionally, CarePartners nurses will speak with a nurse case manager located at Mission Main. (Tr. 1104:10-21.)

Finally, CarePartners nurses perform a transition to ensure that the patient is ready to be discharged from Mission Main. (Tr. 1104:22-25, 1105:1-9.) This involves confirming that there are no outstanding procedures that the patient needs to undergo, and that the patient understands the implications of receiving hospice care. (Tr. 1104:22-25, 1105:1-9.) During this transition period, CarePartners nurses work with the nurse medical case manager at Mission Main, or the patient's provider, which can either be a physician or the palliative care team, and reviews written documentation while making their own recommendation for transition based on their own assessment. (Tr. 1105:21-25, 1106:1-20.) Both CarePartners nurses and Mission Main nurses have the authority to review and chart on these patients. *Id.*

Given the working relationship between Mission Main and CarePartners, there have been instances where nurses working at Mission Main wanted to transfer to CarePartners. (Tr. 1108:19-23.) In fact, both of the hospice nurses that work at CarePartners formerly worked as floor nurses at Mission Main. (Tr. 1108:24-25, 1109:1-2.) Given that these nurses already have the same basic training and foundation that all Mission Health nurses receive, there was very little additional work required to get them transferred and working at CarePartners. (Tr. 1109:15-22.)

xxi. Mission Health Has Centralized Electronic Medical Records.

Mission Health's electronic medical record provider is called Cerner. (Tr. 249:6-19, 438:10-17.) Cerner is designed to allow for inpatient and outpatient encounters, and viewers can see all of the appropriate patient-providers. *Id.* A patient within Mission Health has a single record which can be accessed from any location within Mission Health, as each facility uses the same platform. (Tr. 249:3-25, 250:1-8, 919:13-24.) For example, if a patient is seen at a PSG location and is later admitted to Mission Main, nurses at Mission Main are be able to access the patient's records and determine what happened at the PSG location. (Tr. 249:3-25, 250:1.) If the patient had

been treated outside of Mission Health, however, nurses would not have access to those records. *Id.* The Pyxis medication system is also tied to Cerner and thus provides access to what medications the patient has received. (Tr. 438:10-25.) Nurses use the medical records to design care plans based on a patient's needs and to communicate with one another regarding patient care. (Tr. 1066:3-15, 1068:6-13.) Nurses who provide any level of care are required to document that care after it is provided. (Tr. 1083:7-21.) Nurses who are coming on shift will review a patient's medical record so that they are aware of the patient's current status. (Tr. 1084:7-13.) In addition to nurses, patient care technicians and any provider charts the care provided to patients. (Tr. 1084:21-25, 1085:1-2.) Mission Health's centralized electronic medical records provides additional evidence of its interrelation of operations.

xxii. Mission Health Has Coffee Shops.

There are coffee shops at Mission Main and at 21 Hospital Drive called the Bean Shop. (Tr. 1262:11-19.) Bean Shop employees frequently interchange with one another. *Id.*

f. Centralized Control of Management and Supervision.

In *Stormont-Vail*, the administration and top managerial hierarchy was centralized under an operating committee composed of vice presidents in charge of the various operations. 340 NLRB at 1206.

i. Mission Health's Organization is Centralized.

As explained above, the Employer operates Mission Main, an acute care hospital (which include various out-patient clinics and centers) physician clinics, a long-term, acute care hospital, a rehabilitation hospital, home healthcare, and hospice. (Tr. 34:25, 35:1-24, 42:21-25, 43:1-22.) All of these lines of business ultimately report to Mission Health's CEO, Greg Lowe. (Er. Ex. 1.) The CEO of Mission Main reports directly to Mr. Lowe. (Er. Ex. 1). The physician clinics operate in PSG clinics. (Tr. 43:22-25, 44:1-15, 45:25, 46:1-4.) PSG group is managed by a Vice President

who reports directly to Mr. Lowe. (*Id.*) The rehabilitation hospital and the home healthcare and hospice services are referred to as CarePartners. (Tr. 39:5-25, 40:1-6.; Er. Ex. 1) A Mission Health Senior Vice President manages CarePartners and the long-term, acute care hospital report, and that Senior Vice President also reports to Mr. Lowe. Thus, Mission Health is a centralized operation and this factor militates toward a multi-facility unit. *See*, Section IV.C.

ii. Nurses' Terms and Condition of Employment are Centralized.

As described in Section IV.B.3.d above, the terms and conditions nurses working in Mission Health's facilities within Buncombe County are centralized.

iii. Nurse Management is Centralized.

A nurse reports to the Nurse Unit Supervisor. (Tr. 107:8-20.) The Nurse Unit Supervisor reports to the Nurse Director who reports to a various administrator, who then reports to the Chief Nursing Officer ("CNO"). *Id.* Regardless of the job code or classification, all nurses' report clinically to the CNO, and all departments with RNs have a dotted reporting structure to the CNO. (Tr. 107:21:25, 108:1-7.) Karen Olsen, the CNO, is responsible for being the ultimate supervisory authority over "all nursing through the hospital and its associated entities." (Tr. 53:7-18; 352:10-20.) Ms. Olsen's job duties are not limited to Mission Main; rather, her responsibility also includes the Employer's infusion centers, cancer centers, radiology nurses, outpatient nurses, and physician practices (*i.e.*, Mission Health in Buncombe County.) *Id*. In fact, in addition to Mission Main's inpatient units, Ms. Olsen is also responsible for all nurses in Employer's HOP-Ds. *Id*. Ultimately, all nurses throughout Mission Health in Buncombe County and within the Employer's proposed unit report to the Chief Nursing Officer. (Tr. 371:12-14, 1027:3-25, 1028:1-11.)

iv. Nursing Discipline is Centralized.

As described in Section IV.B.3.d.vii above, discipline for nurses working for Mission Health's facilities in Buncombe County are centralized.

v. Nursing Strategic Plan is Centralized.

Mission Health's Nursing Annual Report demonstrates centralized management of nursing within the system. (Er. Ex. 23.) Significantly, the Annual Nursing Report contains the Nursing Strategic Plan to guide the focus of all nurses working in Mission Health to provide excellent patient and family care. *Id.*

g. Bargaining history.

There is no bargaining history at the Employer. Accordingly, there are no units for the Region to review for inclusion therein.

Based on the foregoing, the substantial weight of the evidence demonstrates that the Employer's multi-facility proposed unit is appropriate as all of the registered nurses working at these facilities share a community of interest. Significantly, there is no evidence to remotely suggest, let alone establish, that the nurses in the Petitioner's petitioned-for unit share a separate and distinct community of interest from the nurses in the Employer's proposed unit. Accordingly, pursuant to the Board's decision in *Stormont-Vail*, the Region should direct an election for those registered nurses in the Employer's proposed unit.

C. Because A Single Employer Relationship Exists Among The Three Corporate Entities That Employ The Mission Health Registered Nurses, Any Appropriate Bargaining Unit Must Include All Registered Nurses Of These Three Corporate Entities In Buncombe County.

The evidence demonstrates that the Employer is a single, integrated enterprise such that employees of MH Manager, MH Asheville, and MH Multispecialty Providers must be considered

a single employer. As explained in *NLRB v. Browning-Ferris Industries, Inc.*, 691 F.2d 1117, 1122 (3d Cir. 1982):

> A 'single employer' relationship exists where two nominally separate entities are actually part of a single integrated enterprise so that, for all purposes, there is in fact only a 'single employer.' The question in the 'single employer' situation, then, is whether the two nominally independent enterprises, in reality, constitute only one integrated enterprise

The controlling criteria used by the Board in determining whether integration is sufficient for single-employer status are:

> (1) Centralized control of labor relation
> (2) Common ownership or financial control
> (3) Common management
> (4) Interrelation of operations

Radio Union v. Broadcast Serv. of Mobile, 380 U.S. 255, 256 (1965). "[T]he most critical factor is centralized control over labor relations." *Mercy Gen. Health Partners*, 331 NLRB 783, 785 (2000).

The evidence adduced at hearing demonstrates that Mission Main and its related entities in Buncombe County are, in fact, a single employer for purposes of the Act. Accordingly, a county-wide unit of registered nurses is presumptively appropriate, and the Petitioner has not offered any evidence to rebut that presumption.

1. Centralized Control of Labor Relations

The uncontradicted evidence overwhelmingly demonstrates there is centralized control of labor relations among MH Manager, MH Multispecialty Providers, and MH Asheville. As thoroughly explained above, recruiting, onboarding, and orientation are centralized for all three entities. Employees of all three entities, including registered nurses, are subject to the same personnel policies. There is a uniform discipline and discharge policy that applies to employees at all three entities. Moreover, the decision to terminate any Mission Health employee, including any

employee of MH Manager, MH Multispecialty Providers, or MH Asheville must be approved by Ms. Meadows, Mission Health's Vice President of Human Resources. (Tr. 417:18-20.)

Further supporting the centralization of labor relations is the fact that Ms. Meadows is responsible for the North Carolina Division, which includes Buncombe County. (Tr. 183:11-24; Er. Ex. 1) Reporting directly to Ms. Meadows is Nyema Sayed, a Vice President of Human Resources, who is responsible for the HR personnel shared by the hospitals, including those in the Employer's proposed unit, as well as all associate entities that report through to the hospitals. (Tr. 56:7-14; 183:11-24; Er. Ex. 1.) Thus, daily labor operations are centralized and are all controlled by the Mission VP of HR. (Tr. 112:4-20). The testimony of HR Manager Chris Rominger supports Employer's position that the Employer's HR functions are centralized and support several locations within the Employer's North Carolina Division, including those in the Employer's proposed unit. (Tr. 181:20-182:16). Ultimately, while certain practice, clerical, and administrative staff may report to a different HR Business Partner, all of Mission Health's human resources functions report to the same Vice President of Human Resources. (Tr. 112:4-20).

Moreover, as discussed above in Sections IV.B, C, and D, the Employer maintains centralized recruiting, onboarding, drug testing, discipline, and termination processes that are applicable to all registered nurses. Further, Mission Health's Leadership Launch program is applicable to all eligible RNs. Finally, it has a centralized laundry service, access department, and pharmacy, which allows has a centralized medication diversion team, who has the authority to send employees suspected of diversion for testing. (Tr. 441:8-25, 442:1444:16-25, 445:1-3, 446:1-25, 447:1-25.)

The centralized approach with respect to new employees is further evidenced by the common orientation sessions all new employees are required to attend. Every other Monday,

Mission Health conducts orientation for the 80 to 130 new employees who are starting work at any of the facilities located in Mission Health, including Buncombe County. (Tr. 187:3-9.) All employees attend the same orientation session regardless of whether their employer is MH Manager, MH Multispecialty Providers, or MH Asheville. (Tr. 187:18-25, 188:1-22.) Mission Health is able to conduct one joint orientation because it has one set of human resources policies and one package of benefits that apply to all employees throughout the North Carolina Division, including those in Buncombe County. (Tr. 185:19-25, 186:1-25, 187:1-2). The orientation session have been held on the fifth or sixth floor of the 1 Hospital Drive building. (Tr. 187:10-17.)

Mission Health's CEO, Mr. Lowe, provides introductory remarks to all attendees. (Tr. 191:4-25, 192:1; Er. Ex. 11.)

Following Mr. Lowe's introductory comments at the orientation, there are numerous presentations addressing Mission Health's policies, including those dealing with code of conduct and care of the patient. (Tr. 191:2-25; 192:1-25, 193:1-25, 194:1-21; Er. Ex. 11.) Mission Health is able to provide joint training on these policies to all new employees throughout the North Carolina Division because the policies apply uniformly across the Division. (Tr. Tr. 185:19-25, 186:1-25, 187:1-2). There is one period during the orientation when attendees are divided into two groups to cover patient safety. (Tr. 191:2-25; 192:1-25, 193:1-25, 194:1-21; Er. Ex. 11.) The attendees are not assigned to either of the groups based on the identity of their employer, their work location, or whether they will work in an in-patient or out-patient setting. *Id.* Rather, the attendees are divided based on whether they primarily will be providing direct patient care. *Id.* Thus, one group is identified as "clinical," and the second group as "non-clinical." (*Id.*) Moreover, nurse practitioners and CRNAs attend the clinical session along with registered nurses because of their similar duties of providing patient care. (Tr. 193:3-14.) In contrast, Physicians attend the

non-clinical session. (Tr. 193:18-22.) Accordingly, the evidence overwhelmingly demonstrates that Mission Health maintains centralized control of labor relations, regardless of the entity for whom a registered nurse works. Thus, the Employer has satisfied the most critical factor in determining single-employer status.

2. Common Management

The record evidence overwhelmingly demonstrates there is common management among employees employed by MH Manager, MH Multispecialty Providers, and MH Asheville. "The issue is not whether there is any separate managers at all but 'whether there exists overall control of critical matters at the policy level.'" *Fareri Assocs., LP* , 2019 NLRB LEXIS 277, *174 (2019) (quoting *Esming's Supermarket, Inc.*, 284 NLRB 302 (1987), enfd. 872 F.2d 1279 (7th Cir. 1989). Indeed, "[t]he fact that day-to-day management is handled at the local level is not controlling." *Dean E. Norris, Inc.*, 2012 NLRB Reg. Dir. Dec. LEXIS 52, *30 (2002) (citations omitted). Common management at the corporate level is sufficient for a single-employer finding. *Centra, Inc.*, 1996 NLRB LEXIS 475, *32-33 (1996).

As explained above, all Mission Health business lines ultimately report to Mr. Lowe. (Tr. 38:5-25, 39:1-4; Er. Ex. 1.) Stated another way, all management authority flows directly from Mr. Lowe through the lines of business for whom employees employed by MH Manager, MH Multispecialty Providers, and MH Asheville. Mr. Patrick is the CEO of Mission Main, and all of the entities that fall within the scope of Mission Main. (Tr. 51:12-25, 52:1-4.) Ex. Ex. 1, pp 1, 3.)

Among those reporting directly to Mr. Lowe are: (1) Mickey Pickler, who serves as Vice President of PSG; (2) Tracey Buchanan, who serves as Senior Vice President and CEO of CarePartners; (3) Terence Van Arkel, who serves as Mission Health's North Carolina Division CFO; (4) Kathy Guyette, who serves as the Chief Nurse Executive; (5) William Hathaway, who serves as the Division Chief Medical Officer; (6) Sheila Meadows, who serves as the Vice

President of HR for the North Carolina Division; and (7) Chad Patrick, CEO of Mission Main. (Er. Ex. 1.) Mr. Lowe has weekly meetings with these direct reports, meeting every Wednesday morning. (Tr. 924:5-8.)

Mr. Pickler is the VP of PSG, (Tr. 43:22-25, 44:1-15.) PSG assists Mission Health by providing "hospital-based groups," which includes anesthesia, radiology, pathology, hospitalists, ER physicians, as well as all of the providers. *Id.* The Chief Certified RN Anesthetist, Douglas Roberts, reports up to Mr. Pickler (1188:14-15, 1207:14-22), who in turn reports directly to Mr. Lowe. (924:2-4.) It is undisputed that nurses employed by MH Manager and MH Multispecialty Providers work at PSG locations. (Er. Exs. 3, 5.)

Ms. Buchanan is a Senior Vice President and CEO of CarePartners, which provides several services, including inpatient rehab, home care, hospice, and operates ASH. (Tr. 39:5-23, 43:5-10; Er. Ex. 1.) The employees employed by MH Asheville Specialty Hospital all work at Asheville Specialty Hospital at 428 Biltmore Avenue. (Tr. 41:6-21; Er. Ex. 1-2.) Certain employees employed by MH Manager work at CarePartners' inpatient rehab facility, located at 68 Sweeten Creek Road, working in the Home Health and Hospice departments. (Tr. 42:21-25, 43:1-4; Er. Exs. 1, 3.) Thus, employees employed by both MH Asheville and MH Manager are managed by Ms. Buchanan. (Er. Exs. 1-3.)

Finally, it is undisputed that all nurses, regardless of their employer, report clinically to the CNO, and all departments with RNs have a dotted reporting structure to the CNO. (Tr. 107:21:25, 108:1-7.) Ms. Olsen, the CNO, is responsible for being the ultimately supervisory authority over "all nursing through the hospital and its associated entities." (Tr. 53:7-18; 352:10-20; Ex. 1, p 3) Ms. Olsen reports directly to Mr. Patrick, and has a dotted line report to Kathy Guyette, Mission Health's Chief Nurse Executive. (Er. Ex. 1, pp 2-3.)

It is undisputed that Mr. Patrick, Ms. Buchannan, Ms. Pickler, and Ms. Guyette all report directly to Mr. Lowe. (Er. Ex. 1, p 1.) Accordingly, it is undisputed that the nurses in the Employer's proposed unit in Mission Health's Buncombe County facilities share common executive management. Indeed, all nursing reporting relationships tier to Mr. Lowe. This factor, therefore, heavily favors single employer status. *See Taft Coal Sales & Assocs., Inc.*, 360 NLRB 96, 99 (2014) (common management factor "heavily favors single-employer status" where entities share executive-level management).

3. Common Ownership or Financial Control

The undisputed evidence conclusively establishes common ownership among MH Manager, MH Multispecialty Providers, and MH Asheville. In particular, MH Manager and MH Asheville are both wholly-owned, direct subsidiaries of MH Hospital Holdings, Inc. (Tr. 564:11-19; Er. Ex. 5.) In addition, MH Hospital Holdings, Inc. holds all of the ownership in all entities holding ownership interest in MH Multispecialty Providers. (Tr. 48:1-25, 49:1-6, 565:22-25, 566:1-3; Er. Ex. 5). As a result, MH Manager, MH Multispecialty Providers, and MH Asheville all share common ownership.

Glen Mortensen, Assistant Vice President of Tax, confirmed this information during his testimony at the hearing. Mr. Mortensen supports HCA Healthcare's development team on tax aspects of mergers and acquisitions. (Tr. 561:25, 562:1-10.) In preparation for the acquisition of Mission Health in early 2019, he prepared a chart showing a graphical representation of the ownership interests among MN Hospital Holdings, Inc. and its various subsidiaries. (Tr. 562:20-25, 563:1-10.) Mr. Mortensen's chart, with funding information redacted, was introduced as Employer Exhibit 5 at the hearing. (Tr. 104:5-17, 569:8-10; Er. Ex. 5.) Mr. Mortensen confirmed Employer Exhibit 5 accurately shows MH Hospital Holdings, Inc. directly or indirectly holds all of the ownership interests in MH Manager, MH Multispecialty Providers, and MH Asheville. (Tr.

48:1-25, 49:1-6, 564:11-19, 565:22-25, 566:1-3.) The Petitioner introduce no evidence concerning the ownership of these three entities. Accordingly, it is undisputed that MH Manager, MH Multispecialty Providers, and MH Asheville all share common ownership.

4. Interrelation of Operations

"Satisfaction of this factor require evidence of functional integration between two companies, which often includes evidence of shared facilities, equipment, and personnel." *Rogan Bros. Sanitation, Inc.*, 362 NLRB 547, 550 (2015). An "absence of an arm's length- relationship between the two companies…supports the finding of interrelated operations." *Id.* at 551. The uncontradicted evidence overwhelmingly demonstrates interrelation of operations between MH Manager, MH Multispecialty Providers, and MH Asheville. The Employer refers the Region to the facts adduced regarding "Functional Integration" and "Terms and Conditions of Employment", above, as evidence of the significant integration of the Employer's business. See Section IV.B.3.d. and e., above.

Thus, based on the undisputed evidence, MH Manager, MH Multispecialty Providers, and MH Asheville are a single, integrated employer for purposes of collective bargaining. Indeed, the significant weight of evidence demonstrates that the Employer's operations satisfy the Board's long-standing test for determining single employer status. Accordingly, the Region should determine that MH Manager, MH Multispecialty Providers, and MH Asheville are a single employer and, therefore, the Employer's proposed unit of all registered nurses work for that single employer and constitute an appropriate unit.

D. Unit Composition Issues

1. Nursing Team Leads Are Not Supervisors.

Employees are to be included in the unit unless it is clear from the evidence that the employee meets the criteria of a 2(11) supervisor under the Act. Here, Petitioner does not seek to

exclude the position of Team Lead, nor does the Employer. The evidence in the record supports that result, with the exception of the one Infusion Team Lead in the Cancer Center's integrative health area. The undisputed evidence as to RN Lead Nall is that she disciplines employees, identifies problems, approves vacations, recommends merit pay raises, and reports directly to the same manager as the Nurse Unit Supervisor. (Tr. 507:1-25, 508:1-8, 509:1-14.)[9] No other evidence was adduced showing any other Lead meets the 2(11) criteria.

2. Nurse Practitioners & CRNAs Must Be Included In the Unit.

a. Nurse Practitioners

Based on the Petition, as well as its withdrawal from a pre-hearing stipulation, it is evident that the Petitioner will seek to exclude nurse practitioners from a unit composed of all RNs. Such an exclusion, however, contravenes extant Board precedent, which dictates the inclusion of nurse practitioners in the unit.

In *Rockridge Medical Care Center*, 221 NLRB 560 (1975), the Board determined nurse practitioners are properly included in a unit comprised of nurses. In support of its position that the nurse practitioners should be excluded from the RN unit, the employer argued the duties, function, and elevated professional standing of nurse practitioners clearly distinguish and set them apart from RNs. *Id.* In addition to different duties, the employer argued that nurse practitioners are paid a salary which is approximately 20 percent higher than that received by RNs, they are not required to wear uniforms, and they participate in medical staff meetings with the physicians; yet, RNs are required to wear uniforms and do not attend medical staff meetings. *Id.* at 560-61

[9] For example, one witness testified that her leads had the authority to responsibly direct or assign work to employees, resolve grievances, and issue discipline to other employees (Tr. 1055:21-25, 1056:1-25, 1057:1-4), but she provided only conclusory testimony in that regard which is insufficient to establish supervisory status such that those RNs should be excluded from any unit. *See Golden Crest Healthcare Ctr.*, 348 NLRB 727, 731 (2006) ("purely conclusory" evidence is not sufficient to establish supervisory authority).

The Board, however, found these arguments unpersuasive. *Id.* at 561. The Board found evidence that the entries made by nurse practitioners on a patient's medical records as to evaluation and treatment must be reviewed and signed by a physician, and any prescriptions written by them must be countersigned by physicians. *Id.* The Board, therefore, concluded that notwithstanding that nurse practitioners performed certain tasks similar to those performed by physicians, it appeared that the ultimate responsibility for the treatment, drug prescription, and patient diagnosis and care still resided with the licensed physician. *Id.* Accordingly, the Board found, irrespective of their purported differences, nurse practitioners were essentially RNs who had received two years additional education and who were given some additional responsibilities. *Id.* Because of the similar educational background, training, and not too dissimilar functions of nurse practitioners and registered nurses, the Board concluded nurse practitioners should be included in the RN unit. *Id., see also McLean Hospital Corporation,* 311 NLRB 1100, 1103 (1993) (including nurse practitioners in a registered nurse unit).

Further, in *St. Catherine of Siena Medical Center*, 2006 BL 189052 (2006), the Regional Director concluded the nurse practitioners in dispute should be included in an RN unit. Specifically, the Regional Director found unpersuasive arguments that because they possessed an additional certification, nurse practitioners somehow had more authority than when the Board decided *Rockridge*, and that the group in dispute was small. *Id.* The Regional Director found that including nurse practitioners in the registered nurse unit comported with Congress' admonition against the undue proliferation of units, and supported by Board precedent. *Id.* Notably, with respect to precedent, the Director stated that he found no reason to disregard *Rockridge* even though the decision occurred prior to adopting the Rules. *Id.*

In 2013, a Regional Director examined Board precedent and guidance in determining whether to include acute care nurse practitioners in the RN unit in dispute. *Suter Bay Hosps.* 2013 NLRB Reg. Dir. Dec. LEXIS 125 (2013). Specifically, the Director stated, "[n]urse practitioners are generally included in RN units if they are required to be RNs." *Id.* at *24 (citing *Rockridge Med. Care Ctr.*, 221 NLRB 560, 561 (1975), Memorandum from NLRB General Counsel on Health Care Unit Placement Issues to Regional Directors, Officers-in-Charge, and Resident Officers (June 5, 1991), https://www.nlrb.gov/guidance/memos-research/general-counsel-memos.)) The Regional Director also cited *McClean* in support of this determination. *Id.* Notwithstanding the petitioner's argument that nurse practitioners should be excluded because they had additional training, licensure, and authority, and are authorized to order and perform many procedures and prescribe and administer medications, which the petitioned-for RNs were not authorized to do, the Regional Director declined to exclude the nurse practitioners from the unit. *Id.* at *25. The Regional Director based this determination on the fact that the nurse practitioners worked almost exclusively on a campus with nurses, were required to be RNs, provided direct patient care, and interacted on a daily basis with patients, the petitioned-for RNs, and with other medical staff. *Id.* The Regional Director, therefore directed the nurse practitioners' inclusion within the unit of nurses.

Here, it is clear that the Employer's nurse practitioners should be included in the unit. First, like the Board determined in *Rockridge*, the Employer's nurse practitioners are of a similar educational background and training from Employer's RNs (and CRNAs, as described below). Indeed, it is undisputed that nurse practitioners must be a RN and maintain a current RN license in order to hold that position. (Tr. 713:24-25, 714:1; Er. Ex. 17.) To be sure, Petitioners have not put forward any evidence to contradict this fairly uncontroversial point.

Also like the Board in found in *Rockridge*, the Employer's nurse practitioners perform many of the same duties of a RN. (Tr. 895:25, 896:1-25, 897:1-19.) For example, Nicole Baker, a nurse practitioner for Mission Main in the outpatient neurology clinic, who was called as a witness by the Petitioner testified that as she is the only RN in her clinic and thus she performs the duties that require a RN license. (Tr. 871:21-24, 895:11-18.) On cross-examination, Ms. Baker conceded that she performs many of the same duties that RNs perform, as expressly set out in the RN job description. (Tr. 895:25, 869:1-25, 897:1-19; Pet. Ex. 8.) Specifically, Ms. Baker testified that, as a nurse practitioner, she performs the following duties required of registered nurses per the job description: (1) oversees the delivery of patient care; (2) delegates patient care based on patient needs and the staff she has available at the time; (3) evaluates the patient; (4) formulates a plan of care for the patient; (5) revises the patients plan of care from time to time; (5) documents in an accurate and timely manner the care she provides to the patient; (6) monitors the patient's well-being; (7) identifies any problems the patient encounters; and (8) implements measures to meet the needs of the patient. *Id.*

Michael Newman, Director of Operations for Mission Health's PSG, likewise confirmed that nurse practitioners share many of the same skills as RNs, such as being well versed in managing patients and medication as well as being strong clinic practitioners. (Tr. 1304:2-9.) Indeed, the Employer's nurse practitioner job description clearly states in the "Role Summary" section that nurse practitioners work in compliance with the North Carolina Board of Nursing, and lists an essential accountability of a nurse practitioner as demonstrating standards of a "Mission Health Professional Nurse" according to the Mission Health Guiding Principles. (Pet. Ex. 9.) Subsection 9 of Section 6 specifies that a nurse practitioner, like RNs and CRNAs, must own their "nursing practice" and apply the "nursing process when developing nursing plans of care for each

patient (or in daily work)." (Pet. Ex. 9.) To be sure, these same guiding principles are set forth in the RN job description, and the nurse practitioner "MERIT standards of performance" are identical to those on the RN job description as well. (Pet. Exs. 7, 9.) As Director of Ambulatory Nursing, Barbara Noon testified, nurse practitioners must have nursing oversight for these nursing duties and, for those nurse practitioners at the PSG locations, Noon provides that. (Tr. 691:20-25, 692:1-2, 1305:11-18.) Moreover, with regard to the other duties allocated to these nurses, it is undisputed those duties must be overseen by a physician, as the nurse practitioner cannot otherwise perform any of them – clearly placing her outside any health care unit other than registered nurse.

Additionally, Employer's nurse practitioners are required to be, and work closely with the Employer's nurses to provide direct patient care, and to interact on a daily basis with patients, the nurses, and with other medical staff. *See Suter Bay*, 2013 NLRB Reg. Dir. Dec. LEXIS at *25. In fact, Katy Pless, Human Resources Manager for CarePartners health services and Asheville Specialty Hospital, testified that RNs and nurse practitioners at PACE interact on a regular basis. (Tr. 605:14-24.) This interaction is so frequent that RNs and nurse practitioners have team meetings wherein they receive the plan of care for all of their patients and regularly collaborate throughout the day. (Tr. 605:20-25.) For example, RNs often consult with nurse practitioners on how to handle patient concerns. (Tr. 605:25. 606:1-5.) Additionally, at Mission Main, nurse practitioners and RNs are granted the same opportunities for redeployment to high census areas. (Tr. 607:5-21.) In fact, Employer's nurse practitioners can pick up shifts as RNs, necessarily indicating that they will "work closely" with other RNs. (*See* Section IV.B.3.e.j, above).

Numerous other examples of these interactions and integration are present throughout the Employer's proposed unit with regard to nurse practitioners. For example, Susan Stevens a Vice President of Human Resources for Mission Health, supports all nursing personnel, including RNs,

nurse practitioners, CRNAs, and midwives. (Tr. 647:12-25.) Ms. Stevens testified that at Mission Main, Chief Nursing Officer Karen Olsen, Regional Vice President of Human Resources Sheila Meadows, and herself are all involved in any decision to terminate a nurse practitioner. (Tr. 691:1-19.) Further, at Asheville Specialty Hospital and at PACE, nurse practitioners work alongside the registered nurses. (Tr. 544:19-21, 605:14-25, 606:1-5.)

Thus, based on the foregoing, the Region should include nurse practitioners in the unit of registered nurses.

b. Certified Registered Nurse Anesthetists

Similarly, the Petitioner contends that CRNAs should not be included in the unit of RNs. Again, however, the Petitioner's argument is simply not supported in light of the weight of the authority concluding otherwise.

In decisions issued pre-Rule, the Board consistently found CRNAs should be included in RN units. Indeed, the only early decision in which the Board found otherwise occurred when the parties not only stipulated to not including the CRNAs in the RN unit, but the duties, working space, and pay for CRNAs and RNs were wholly distinct. *Long Island*, 256 NLRB 202, 207 n. 21 (1981). In *Trustees of Noble Hospital*, the Board included CRNAs in the RN unit, stating in relevant part: "[CRNAs] function along with other surgical personnel, including registered nurses, as a medical team," and "[t]hey accompany patients to the recovery room where, along with the recovery room registered nurse, they help care for the patient during recovery." 218 NLRB 1441, 1444 (1975). That same year, the Board in *Kaiser Foundation Hospitals* included CRNAs in the nurses' unit based on the fact that the CRNAs must possess a license as an RN, as well as certification as a nurse anesthetist, and the CRNAs are required to possess 1 year of practical experience as an RN or RNA. 219 NLRB 325, 326 n. 2 (1975). The Board agreed stated "nurse anesthetists are basically registered nurses who take additional training." *Id.*

A few years later, the Board again concluded CRNAs were appropriately included in the RN unit. *Addison-Gilbert Hosp.*, 253 NLRB 1010 (1981). Specifically, the Board found the nurses employed in the employer's division of nursing services and the two CRNAs shared a common community of interest separate and distinct from the other alleged professionals about whom the employer presented evidence. *Id.* The Board stated, in relevant part, that, "[t]his is true not only in the type of work performed concerning direct patient care, but in educational and licensing requirements imposed by the State, the hours of work and the pay received, and the separate supervision . . . ." *Id.* Furthermore, even following the Board's promulgation of the Rules, it has still been found appropriate to include CRNAs in RN units. *See Sinai Health Sys*, 2007 NLRB Reg. Dir. Dec. LEXIS 165 (2007).

Here, like in *Kaiser Foundation Hospitals* and *Addison-Gilbert Hospital*, the testimony shows that the Employer's CRNAs are RNs with additional training. Indeed, it remains undisputed that all of the Employer's CRNAs are all required to hold a RN license, and are overseen by the North Carolina Board of Nursing. (Tr. 712:6-8; 1189:16-23; Er. Ex. 17.) Coupled with the fact that the Petitioner has failed to put forward any evidence that CRNAs share a community of interest with any other group of purported professionals, their inclusion in the unit is appropriate.

Additionally, as in *Trustees of Noble Hospital*, the Employer's CRNAs function along with other surgical personnel, including registered nurses, as a medical team. Indeed, the testimonial and documentary evidence presented at hearing show that the Employer's CRNA job description states that the CRNA position must meet the standards of a "Mission Health Professional Nurse" pursuant to the Mission Health Guiding Principles. (Pet. Ex. 7.) Notably, the Mission Health Guiding Principles' Performance Criteria requires CRNAs, like all RNs, to own their nursing practice and apply "the nursing process when developing nursing plans of care for each patient (or

in daily work)." (Pet. Ex. 7) Those guiding principles are identical to those for the Employer's RN job description. (Pet. Exs. 7, 8.) Likewise, the "MERIT standards of performance" for CRNAs are identical to those for the Employer's RNs. *Id*

Moreover, the Employer's CRNAs perform most of the same job duties that nurses perform, including those found in the Employer's RN job description. (Tr. 1195:7-16; Pet. Ex. 8.) Specifically, a comparison of job duties shows that nurses oversee "the delivery of patient care for a group of patients, and directs and delegates patient care based on patient acuity," while, similarly, CRNAs direct and delegate patient care based on the acuity of the patient. (Tr. 1195:7-16; Pet. Ex. 8.) The RN job description also states that nurses collaborate and consult with "patients, colleagues and interdisciplinary team members to achieve desired outcomes." (Pet. Ex. 8.) Like these nurses, CRNAs collaborate and communicate with their team members in the operating room – typically a circulating nurse, a scrub technician, and a surgeon, and that all of those individuals together as a team. (Tr. 1192:8-16.)

The Employer's RN job description also states that nurses provide patient education. (Pet. Ex. 8.) Likewise, CRNAs educate patients during the pre-op stage of surgery with information regarding what the patient can expect from the anesthetic they are going to receive. (Tr. 1199:14-22.) This factor was important to the Board in *Sinai Health System*, wherein the Regional Director included CRNAs in the RN unit, notwithstanding the fact that the CRNAs reported to the Chief Anesthesiologist, rather than the nursing staff, and in spite of the CRNAs' and RNs' differing work schedules. 2007 NLRB Reg. Dir. Dec. LEXIS at *35-43. Despite those facts, the Regional Director found that the employer offered sufficient evidence in support of inclusion based on the facts that the CRNAs and RNs had the same involvement in patient care, identical licensing requirements,

and worked side-by-side in operating room sufficient evidence for inclusion. *Id.* In further support of his decision to include the CRNAs in the RN unit the Regional Director noted:

> exclusion from the unit would result in the creation of a potentially unrepresented residual unit within the RN unit resulting in the proliferation of bargaining units in a health care setting, which is contrary to the Board's Rule on the structure of bargaining units in the health care industry.

Id.

Like the CRNAs in *Sinai Health System*, the Employer's CRNAs and RNs regularly work closely with one another during on matters of patient care, including during patient "hand offs," which occur between the preoperative and operation stages of a surgical case. (Tr. 1191:7-10.) During these hand offs, the preoperative nurse will hand the patient off to the circulating nurse, both of which are RNs, and then to the CRNA. (Tr. 1191: 18-21.) The preoperative nurse, the circulating nurse, and the CRNA work together to discuss the patient's allergies, any medications the patient may have received during the pre-operation process, and other matters relevant to achieving patient care. (Tr. 1191:13-17).

During surgery, CRNAs also work hand in hand with nurses by collaborating and assisting one another. (Tr. 367:10-25.) For example, Kristi Hensley, Director of Asheville Surgery Center and a registered nurse, testified that during a procedure: (1) a CRNA may ask a circulating nurse to retrieve medication if there is an immediate need; (2) if a CRNA has left the operating room, and the scrub nurse needs a sterile supply open to the surgical field, the scrub nurse will ask the CRNA to open the supply and present it to the surgical field; (3) the circulating nurse and CRNA work with one another to ensure the patient is in the proper position during the surgery; and (4) if the scrub nurse observes excessive bleeding at the surgical site, the scrub nurse may query the CRNA as to the patient's blood pressure or if the patient's muscles seem tight. (Tr. 367:10-25,

368:1-6.) Ms. Hensley testified that "[t]his sort of communication is carried out throughout the procedure amongst the team." (Tr. 367:10-25.)

Additionally, Mr. Hoaglan, a circulating nurse in Mission Main's operating room, testified that the duties of a circulating nurse include working with the surgical team members, consisting of the CRNA, the surgeon, and the scrub technologist. (Tr. 758:14-24.) Mr. Hoaglan testified that, as a circulating nurse, he works with CRNAs on intubation and makes himself available for procuring supplies. (Tr. 759:8-13.) He also confirmed that the circulating nurse and CRNA jointly escort patients to recovery. (Tr. 778:17-19.) Mary Pat Gilligan, AVP of Periopertative Services at Mission Health, additionally testified that, if a circulating nurse needs to leave the operating room, the circulating nurse alerts the CRNA before leaving the room. (Tr. 397:2-11.) Ms. Gilligan testified that alerting the CRNA before leaving the room is "part of the nurse-to-nurse handoff" and that such communication ensures everyone is on the same page. (Tr. 397:12-23.)

Following surgery, a similar handoff process to the pre-operation process occurs between the nurses, wherein the CRNA and the circulating nurse handoff the patient to the post-anesthesia care unit ("PACU") nurse, who is also an RN. (Tr. 399:9-19, 1194:2-13.) During the post-surgery handoff, the circulating nurse and CRNA debrief the PACU nurse regarding the patient's physical state. (Tr. 399:20-25, 400:1-8, 1194:2-13.)

This overall integration and commonality among the Employer's CRNAs and RNs is also evident in situations where Employer must terminate a CRNA. In those instances, the Employer's senior RN leader and a member of the Human Resources department participate in the decision making process. (Tr. 691:1-11). The senior RN leader is involved in the decision making process because CRNAs hold a RN license and anyone that holds a RN license ultimately reports to another RN. (Tr. 691:14-18.) Susan Stevens, a Vice President of Human Resources for Mission Health,

testified that at Mission Main, Chief Nursing Officer Karen Olsen, and Regional Vice President of Human Resources Sheila Meadows, and herself are involved in the decision to terminate CRNAs. (Tr. 691:1-19.) Therefore, and despite the Union's unsubstantiated argument otherwise, the CRNAs should be included in the RN unit.

3. The Petitioner Cannot Demonstrate that the Employer's Proposed Unit Is Inappropriate.

Based on the arguments raised at the hearing, it is likely that the Petitioner will contend that the Employer's proposed unit of all RNs working for Mission Health Buncombe County is an arbitrary grouping of nurses because it does not contain all nurses from the North Carolina Division of HCA Healthcare. Effectively, the Petitioner is arguing that that a larger, multi-location unit is appropriate. While the Employer readily admits that the North Carolina Division encompasses areas outside of Asheville and Buncombe County (Tr. 178:2-22), this does not render the Employer's proposed unit arbitrary. Indeed, when "considering the appropriateness of multi-location unit, the Board has long held, consistent with community of interest considerations, that for a unit to be appropriate, it must be, 'sensible for collective bargaining from the standpoint of geographic considerations or the employer's administrative or operational structure.'" *Nelson Tree Serv.*, 1999 NLRB Reg. Dir. Dec. LEXIS 11, *11 (1999) (quoting *State Farm Mut. Auto. Ins. Corp.*, 159 NLRB 925, 930 (1966).

As set out in detail above, the majority of the employee interchange and the functional integration occurs among Mission Health facilities located in Buncombe County. In addition, the scope of many of the operations are limited to Mission Hospital and its associated locations in Buncombe County. In addition, Mr. Rudisill, the COO of Mission Hospital, testified that Michael Maggard was responsible for registration and scheduling for Mission Main and "its associated locations," Mr. Rudisill testified Mr. Maggard did not perform those same duties on behalf of other

hospitals and facilities located outside of Buncombe County, such as McDowell. (Tr. 946:2-12.) In fact, Mr. Rudisill was not aware of the identity of the individual who performed those functions. (Tr. 946:13-15.) Also, Mr. Rudisill testified that John Ehrhart, Director of Case Management for Mission Main "and its associated facilities[,]" is not responsible for performing those duties for the entire North Carolina Division. (Tr. 947:20-25, 948:1-8.) Instead, Mr. Ehrhart simply has a dotted line report up to a Division Director of Case Management who oversees the locations that are not associated with Mission Main, which are outside of Buncombe County. (Tr. 948:4-25, 949:1-2.)

It is clear from the record evidence that Mission Health nurses employed outside of Buncombe County have a community of interest sufficiently distinct such that they should not be included in a unit with the nurses working at Mission Health facilities within Buncombe County. Accordingly, the Employer's proposed unit is properly bound by the geographic lines of Buncombe County. , The Region, therefore, should reject the Petitioner's argument for a Division-wide unit.

E. Petitioner's Proposed Unit Is Also Inappropriate Because It Is Based Solely Upon The Petitioner's Extent Of Organization

Section 9(c)(5) of the Act states: "In determining whether a unit is appropriate…the extent to which the employees have organized shall not be controlling." 29 U.S.C. §159(c)(5). Section 9(c)(5) is an explicit statutory prohibition against basing a unit appropriateness determination *solely* upon a Petitioner's extent of organization.

Throughout the course of this brief, the Employer has demonstrated that Petitioner's petitioned-for unit is an arbitrary grouping of some of its registered nurses that does not comport with extant Board law. As the evidence establishes, the petitioned-for unit fails to comply with the Rule, and, significantly, fails to include registered nurses within the Mission Health system that

do not have a distinct community of interest from those in the petitioned-for units. Such "picking and choosing" by the Petitioner raises a logical and reasonable inference that Petitioner's proposed unit is based solely on its extent of organization. *See*, Member Hurtgen's dissent in *Overnite Transp. Co.*, 325 NLRB 612 at 615 (1998). "Obviously, a union's desire to include or exclude a group of employees will reflect the extent to which it has succeeded in organizing that group. Thus, the proscription of Section 9(c)(5) is directly implicated."

Here, at the outset of the hearing the Petitioner agreed additional employees should be included in the unit and entered into a stipulation to that effect. After the Employer had presented its case in chief, the Petitioner decided it wished to withdraw from the stipulation. Even though the Region asked for an explanation for this request, the Petitioner never provided one and instead insisted it must be allowed to proceed "in the direction it wishes." (Bd. Ex. 7.) The inability of the Petitioner to provide any explanation for its refusal to honor the stipulation it proposed strongly suggests the true reason for its insistence that it be allowed to return to its petitioned-for unit is that its position was based solely on the extent to which employees have organized. For this additional reason, the petitioned-for unit is inappropriate.

V. THERE IS NO ADEQUATE BASIS FOR DEPARTING FROM THE BOARD'S PREFERENCE FOR MANUAL ELECTION

The Board has a "longstanding policy. . . that representation elections should, as a general rule, be conducted manually." *NLRB Case Handling Manual*, § 11301.2*; see also Willamette Indus. Inc.*, 322 NLRB 856 (1997) ("under existing Board precedent and policy, the applicable presumption favors a manual election, not a mail-ballot election."). The Case Handling Manual identifies the following situations where it may be appropriate to deviate from the longstanding norm of manual elections:

(a) where eligible voters are "scattered" because of their job duties over a wide geographic area;

(b) where eligible voters are "scattered" in the sense that their work schedules vary significantly, so that they are not present at a common location at common times; and

(c) where there is a strike, a lockout or picketing in progress.

NLRB Case Handling Manual, § 11301.2. The Manual advises that if one of these situations exist, the Regional Director should still "consider the desires of all the parties" before deciding to deviate from the Board longstanding policy favoring manual elections. *NLRB Case Handling Manual*, § 11301.2. Here, none of these situations exists, nor is there adequate reason to utilize a mail ballot.

The Petitioner argued at the hearing that due to COVID-19 concerns, a manual election is not appropriate. Despite the Petitioner's claim, there is no basis to believe a manual election poses any danger to employees or Board agents. As an initial matter, it should be noted that Mission Health has continued to operate since issues with COVID-19 first arose in North Carolina. It took precautions and prepared to redeploy staff so it could adequately handle the anticipated surge in patients, which ultimately never occurred. As concerns about a surge have passed, Mission Health is returning to normal operations. As an example, it is once again performing elective surgeries.

Mission Health has instituted procedures to protect everyone entering its facilities. It conducts screening at its entrances and checks each person's temperature. In addition, it is observing universal masking and providing masks as needed. During the times these procedures have been in place, nurses and other employees have worked thousands of shifts in Mission Health facilities. The Petitioner did not identify any issues that arose with these procedures.

As stated during the hearing, Mission Health proposes these same procedures could be followed during manual voting. In addition, it would provide adequate supplies of disposable gloves to be donned in the polling area to minimize any concern about transmission via items

touched by more than one person, such as the voter lists, the ballots, and writing utensils. The Petitioner failed to identify any specific concerns or inadequacies with these procedures.

The Petitioner claimed at the hearing that all seven of the Regional Directors who handled R case petitions in the last month have ordered mail ballots because of the extraordinary conditions. That is not accurate. On April 14, 2020, the Regional Director of Region 7 ordered a manual election, but held the election in abeyance due to "the nature of the Employer's acute health care operations." *Henry Ford Macomb Hospital - Mt Clemens Campus*; Case 07-RC-256592. The Petitioner failed to identify the seven representation cases it referenced, where those cases were located, or when the Regional Directors issued their decisions. One fact about dealing with COVID-19 that has become evident since its outbreak in the United States is that individual circumstances in a particular locale must be considered. In addition, conditions change over time. The factors that existed in other locations when other Regional Directors directed mail ballots likely have changed. In this case, the acting Regional Director should decide whether there are adequate reasons to depart from the Board's long-standing policy in favor of a manual election based on the conditions at Mission Health and in Asheville, not on what is occurring in other parts of the country. In addition, that decision should be made based on the conditions existing at the time the Decision and Direction of Election issues, not what occurred weeks ago.

Finally, the Petitioner questioned whether Region 10 was adequately staffed to handle a manual election with 2,500+ eligible voters. Region 10 has handled large elections in the past and there is no basis to doubt it can handle a manual election in this case.

For these reasons, the acting Regional Director should not direct a mail ballot. The Petitioner has not identified any compelling reason to depart from the Board's preference for manual elections.

VI. CONCLUSION

Based on the foregoing, the Region should find that the appropriate unit in this issue include all nurses (including nurse practitioners and CRNAs) employed by MH Manager, MH Multispecialty Providers, and MH Asheville within the Mission Health system in Buncombe County. Moreover, the Petitioner has represented that it would not proceed to an election on a unit other than that in the Petition (which is inappropriate). (Tr. 1409:23-25, 1410:1-8.) Given the conclusion that the Region should reach regarding the appropriate unit and the Petitioner's representation, the Region should dismiss the Petition. *See West Jersey Health Sys.*, 293 NLRB 749, 752 (1989) (dismissing petition based on union's representation that it did not intend to seek representation of employees in a certain division, where Board determined that a division-wide unit was appropriate).

Dated this 13th day of May, 2020.

Respectfully submitted,

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ATTORNEYS FOR MISSION HOSPITAL

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 13th day of May, 2020, a true and correct copy of the foregoing was electronically filed with the National Labor Relations Board using its Agency website; and a copy was served via email served via email on the following:

Anthony J. Tucci (atucci@calnurses.org).

David Willhoite (DWillhoite@CalNurses.Org)

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By: /s/ Paul R. Beshears
Paul R. Beshears

WSACTIVELLP:11506864.1

APPENDIX A

1 Hospital Drive

Care Management

Job Title	# of EEs	Employer
RN Care Manager I	36	MH Manager*
RN Care Manager II	4	MH Manager
Case Mgmt Sys Util Mgmt Govt I	4	MH Manager
Continuum Care Manager I	7	MH Multispecialty Providers*
Continuum Care Manager II	1	MH Multispecialty Providers

*MH Manager stands for MH Hospital Manager, LLC
*MH Multispecialty Providers stands for Mission Health Community Multispecialty Providers, LLC

Clinical Performance Improvement

Job Title	# of EEs	Employer
Analyst – PI Clinical	5	MH Manager
Clinical Quality Data Specialist	1	MH Manager

Center for Clinical Advancement

Job Title	# of EEs	Employer
Clinical Pro Dev Educator	17	MH Manager
Clinical Pro Dev Spec Educator	6	MH Manager
Coordinator – Nursing Data	1	MH Manager
Division LMS Coordinator	1	MH Manager
Mission Health Policy Splst	1	MH Manager
Nurse Residency Coordinator	2	MH Manager
Nursing Pro Dev Educator	1	MH Manager
Registered Nurse	1	MH Manager

Diabetes

Job Title	# of EEs	Employer
Nurse Clinician	4	MH Manager

Disease Management

Job Title	# of EEs	Employer
RN Chronic Conditions Mgr.	1	MH Manager

NCD OneHR

Job Title	# of EEs	Employer
RN Chronic Conditions Mgr.	1	MH Manager

Orthopedic/Trauma

Job Title	# of EEs	Employer
Nurse Practitioner	1	MH Multispecialty Providers

Outpatient Clinical Pharmacy Services

Job Title	# of EEs	Employer
Registered Nurse	3	MH Manager

Quality and Safety

Job Title	# of EEs	Employer
Clinical Outcomes Coordinator	1	MH Manager

Research Institute Administration

Job Title	# of EEs	Employer
Clinical Research Nurse	4	MH Manager
Clinical Research Nurse - MS	7	MH Manager

Surgery Advanced Testing Unit

Job Title	# of EEs	Employer
Registered Nurse	34	MH Manager
Team Leader	2	MH Manager

System Care Management

Job Title	# of EEs	Employer
RN Care Manager I	1	MH Manager

Weight Management Center

Job Title	# of EEs	Employer
Nurse Practitioner	1	MH Multispecialty Providers

Wound Healing and HBO Center

Job Title	# of EEs	Employer
Registered Nurse	10	MH Manager
Wound/Ostomy/Continence Nurse	3	MH Manager
Nurse Practitioner	1	MH Multispecialty Providers

100 Ridgefield Court

Hope Women's Cancer Center

Job Title	# of EEs	Employer
RN – Physician Practice	3	MH Manager
Nurse Practitioner	1	MH Multispecialty Providers
Clinical Research Nurse	1	MH Manager
RN – Oncology Infusion	7	MH Manager

100 Victoria Road

Mission Urology

Job Title	# of EEs	Employer
Nurse Practitioner	1	MH Multispecialty Providers

11 Vanderbilt Park Drive

Mission Children's Specialists

Job Title	# of EEs	Employer
Clinical Sup – OP Hospital Clinic	1	MH Manager

Pediatric Hematology and Oncology

Job Title	# of EEs	Employer
Registered Nurse	4	MH Manager
Nurse Practitioner	1	MH Multispecialty Providers

Pediatric Orthopedics

Job Title	# of EEs	Employer
Registered Nurse	1	MH Manager
Nurse Practitioner	1	MH Multispecialty Providers

Pediatric GI

Job Title	# of EEs	Employer
Registered Nurse	1	MH Manager
Nurse Practitioner	1	MH Multispecialty Providers

Pediatric Neurology

Job Title	# of EEs	Employer
Registered Nurse	4	MH Manager

Pediatric Endocrinology

Job Title	# of EEs	Employer
Registered Nurse	1	MH Manager

Pediatric Comm Transition

Job Title	# of EEs	Employer
Nurse Practitioner	3	MH Multispecialty Providers

Olson Huff Ctr Practice

Job Title	# of EEs	Employer
Registered Nurse	1	MH Manager

Pediatric Psych

Job Title	# of EEs	Employer
Registered Nurse	5	MH Manager

Pediatric Pulmonology

Job Title	# of EEs	Employer
Registered Nurse	1	MH Manager

Pediatric Sedation Support

Job Title	# of EEs	Employer
Registered Nurse	4	MH Manager

1388 Sand Hill Road, Candler, NC

Mission My Care Plus

Job Title	# of EEs	Employer
AP Resident	1	MH Multispecialty Providers
Nurse Practitioner	1	MH Multispecialty Providers

14 Medical Park Drive

Mission Surgery

Job Title	# of EEs	Employer
RN – Physician Practice	2	MH Manager
Nurse Practitioner	1	MH Multispecialty Providers

1940 Hendersonville Road

Health Education Center

Job Title	# of EEs	Employer
Nurse Clinician	1	MH Manager

Administration

Job Title	# of EEs	Employer
Care Manager RN (tele)	6	MH Manager

2 Medical Park

Lactation Outpatient/Retail

Job Title	# of EEs	Employer
Consultant - Lactation	2	MH Manager
Team Lead – Lactation Center	1	MH Manager

Mission Workwell

Job Title	# of EEs	Employer
RN – Physician Practice Lead	1	MH Manager
Lead NP – Occupational Health	1	MH Multispecialty Providers

21 Hospital Drive

Mission Medical Oncology

Job Title	# of EEs	Employer
RN – Physician Practice	9	MH Manager
Nurse Practitioner	1	MH Multispecialty Providers

Cancer Program/OP Infusion

Job Title	# of EEs	Employer
Registered Nurse	7	MH Manager
RN Oncology Infusion	7	MH Manager
RN Oncology Staffing Pool	1	MH Manager
Team Lead Oncology Infusion	4	MH Manager

Radiation Therapy

Job Title	# of EEs	Employer
Registered Nurse	4	MH Manager
Coordinator Cyberknife	7	MH Manager

2100 Ridgefield Boulevard

Women's Specialty

Job Title	# of EEs	Employer
Certified Nurse Midwife	1	MH Multispecialty Providers

222 Asheland Avenue

Carolina Vascular

Job Title	# of EEs	Employer
RN – Physician Practice	1	MH Manager
RN – Physician Practice, Lead	1	MH Manager
Clinical Research Nurse - MS	1	MH Manager

2695 Hendersonville Road, Arden, NC

Vista Family Health

Job Title	# of EEs	Employer
Nurse Practitioner	2	MH Multispecialty Providers

286 Overlook Road

PACE (Program of All-inclusive Care for the Elderly)

Job Title	# of EEs	Employer
Nurse Practitioner	2	MH Multispecialty Providers
Registered Nurse – Pace Prgm	5	MH Manager
Home Care Clinical Coordinator	3	MH Manager

310 Long Shoals Road, Arden, NC

Mission Family and Internal Medicine

Job Title	# of EEs	Employer
Nurse Practitioner	2	MH Multispecialty Providers

Mission My Care Now – Biltmore Park

Job Title	# of EEs	Employer
Nurse Practitioner	5	MH Multispecialty Providers

400 Ridgefield Court

Central Primary Care Triage

Job Title	# of EEs	Employer
RN – Physician Practice	1	MH Multispecialty Providers

Care Access Center

Job Title	# of EEs	Employer
RN – Triage	1	MH Manager

Administration

Job Title	# of EEs	Employer
Nurse Educator	1	MH Multispecialty Providers

Regional Disaster Preparedness

Job Title	# of EEs	Employer
MATRAC Regional HPC	1	MH Manager

41 Oakland Road

Asheville Family Medicine

Job Title	# of EEs	Employer
Nurse Practitioner	2	MH Multispecialty Providers

428 Biltmore Avenue

Asheville Specialty Hospital

Job Title	# of EEs	Employer
Registered Nurse	41	MH Asheville*
Registered Nurse (Wound Care)	2	MH Asheville
Case Manager Dischrg Plnr	1	MH Asheville

* MH Asheville stands for MH Asheville Specialty Hospital, LLC

Behavioral Health (Psych Units)

Job Title	# of EEs	Employer
Registered Nurse	59	MH Manager
Clinical Nurse I	1	MH Manager
Nurse Practitioner	6	MH Multispecialty Providers
Coord – Utilization Review I	1	MH Manager

5 Medical Park Drive

Asheville Surgery Center

Job Title	# of EEs	Employer
Registered Nurse	34	MH Manager
Registered Nurse - Surgery	19	MH Manager

5 Vanderbilt Park Drive

Heart Path

Job Title	# of EEs	Employer
Registered Nurse	5	MH Manager

Asheville Cardiology Associates

Job Title	# of EEs	Employer
RN – Physician Practice	21	MH Multispecialty Providers
Registered Nurse	1	MH Multispecialty Providers

Job Title	# of EEs	Employer
Nurse Practitioner	3	MH Multispecialty Providers
Coordinator – VAD, APRN	1	MH Multispecialty Providers
RN – Electrophysiology Lead	1	MH Multispecialty Providers

509 Biltmore Avenue

Job Title	# of EEs	Employer
Analyst - Stroke Data	2	MH Hospital Manager LLC
Analyst ClinQlty Cred/Peer Rvw	1	MH Hospital Manager LLC
Clin Nurse Splst - Adult Acute	1	MH Hospital Manager LLC
Clin Nurse Splst - Chronic Dis	1	MH Hospital Manager LLC
Clinical Coord Palliative Care	1	MH Hospital Manager LLC
Clinical Coordinator	2	MH Hospital Manager LLC
Clinical Coordinator - Trauma	4	MH Hospital Manager LLC
Clinical Nurse I	188	MH Hospital Manager LLC
Clinical Nurse Specialist	1	MH Hospital Manager LLC
Consultant - Lactation	7	MH Hospital Manager LLC
Coord - Adv Card Clinic, Sr	1	MH Hospital Manager LLC
Coord - Chest Pain STEMI Prog	1	MH Hospital Manager LLC
Coord Mvmt Disorders/Epilepsy	1	MH Hospital Manager LLC
Coord Struct Heart/Valve Prgm	2	MH Hospital Manager LLC
Coordinator - Injury Mgmt	1	MH Hospital Manager LLC
Coordinator - Stroke Program	2	MH Hospital Manager LLC
Coordinator - VAD/RN	1	MH Hospital Manager LLC
Echo Tech - Sonographer Peds	1	MH Hospital Manager LLC
ED Experience Liaison	1	MH Hospital Manager LLC
Emergency Dept Technician	1	MH Hospital Manager LLC
Forensic Nurse Examiner	10	MH Hospital Manager LLC
Injury Prevent/Outreach Coord	1	MH Hospital Manager LLC
Manager - Guest Services	1	MH Hospital Manager LLC
Mgr Surg Svcs Ops & Throughput	1	MH Hospital Manager LLC
Nurse Navigator	13	MH Hospital Manager LLC
Perinatal Nurse Navigator	1	MH Hospital Manager LLC
Quality and Safety Manager	1	MH Hospital Manager LLC
Quality Program Manager	1	MH Hospital Manager LLC
Reg Clinical Coord - Trauma	1	MH Hospital Manager LLC
Reg Mgr - Sterile Processing	1	MH Hospital Manager LLC
Regional Transfer Center RN	19	MH Hospital Manager LLC
Registered Nurse	1094	MH Hospital Manager LLC
Registered Nurse - SP Premium	46	MH Hospital Manager LLC
Registered Nurse - Spec Care	11	MH Hospital Manager LLC
Registered Nurse - Surgery	71	MH Hospital Manager LLC
Registered Nurse - VATT	23	MH Hospital Manager LLC
Registered Nurse- Flight Nurse	12	MH Hospital Manager LLC

Job Title	# of EEs	Employer
Registry Supervisor - Trauma	1	MH Hospital Manager LLC
Research Assist - Respiratory	1	MH Hospital Manager LLC
Respiratory Therapist - RRT	1	MH Hospital Manager LLC
RN - ED Resource Pool	4	MH Hospital Manager LLC
RN First Assistant - O.R.	1	MH Hospital Manager LLC
Team Leader - ER	9	MH Hospital Manager LLC
Team Leader - Nursing Sup Svcs	12	MH Hospital Manager LLC
Team Leader - OB OR/PACU	1	MH Hospital Manager LLC
Trauma Nurse Lead	10	MH Hospital Manager LLC
Wound/Ostomy/Continence Nurse	5	MH Hospital Manager LLC
Coordinator - ECMO Program	1	MH Hospital Manager LLC
Adv Practitioner - ED Triage	3	MH Multispecialty Providers
Certified RN Anesthetist	85	MH Multispecialty Providers
Team Leader - CRNA	4	MH Multispecialty Providers
Nurse Practitioner	16	MH Multispecialty Providers

63 Monticello Road, Weaverville, NC

Mission Family Medicine - Weaverville

Job Title	# of EEs	Employer
Nurse Practitioner	3	MH Multispecialty Providers

68 Sweeten Creek Road

Care Partners Staffing

Job Title	# of EEs	Employer
Clinical Nurse I – CP Staffing	1	MH Manager
RN – CP Staffing	12	MH Manager

Administration

Job Title	# of EEs	Employer
Nursing Pro Dev Educator	2	MH Manager

Home Health

Job Title	# of EEs	Employer
Registered Nurse – Home Health	19	MH Manager
Team Leader – Nursing Unit	1	MH Manager
Case Manager – RN – Home Care	7	MH Manager
Primary Case Manager – RN HH	24	MH Manager
Case Mgr – RN Population Hlth	1	MH Manager

Job Title	# of EEs	Employer
RN – Home Health Coumadin	1	MH Manager

Home Hospice Care

Job Title	# of EEs	Employer
Registered Nurse – Hospice	8	MH Manager
RN – Hospice Admissions	1	MH Manager
Case Manager – RN – Home Care	1	MH Manager
Primary Case Mgr – RN Hospice	15	MH Manager
Triage Case Mgr – RN Hospice	3	MH Manager

Solace Center (Inpatient Hospice)

Job Title	# of EEs	Employer
Registered Nurse	14	MH Manager
Team Leader – Nursing Unit	2	MH Manager
Nurse Practitioner	5	MH Multispecialty Providers

Rehabilitation Hospital

Job Title	# of EEs	Employer
Clinical Nurse I	6	MH Manager
Registered Nurse	44	MH Manager
Team Leader – Nursing Unit	6	MH Manager
Nurse Extern	1	MH Manager
Clinical Educator – Post Acute	1	MH Manager
Case Manager II	6	MH Manager
Nurse Practitioner	4	MH Multispecialty Providers

7 Vanderbilt Park Drive

Interventional Spine

Job Title	# of EEs	Employer
Registered Nurse	6	MH Manager

Mission Spine Center

Job Title	# of EEs	Employer
Registered Nurse	3	MH Manager

890 Hendersonville Road

Mission Neurology Outpatient

Job Title	# of EEs	Employer
Nurse Practitioner	7	MH Multispecialty Providers

Olson Huff Center Practice

Job Title	# of EEs	Employer
Registered Nurse	2	MH Multispecialty Providers

900 Hendersonville Road

Mission Infectious Disease

Job Title	# of EEs	Employer
RN – Physician Practice	1	MH Multispecialty Providers
RN – Physician Practice Lead	1	MH Multispecialty Providers

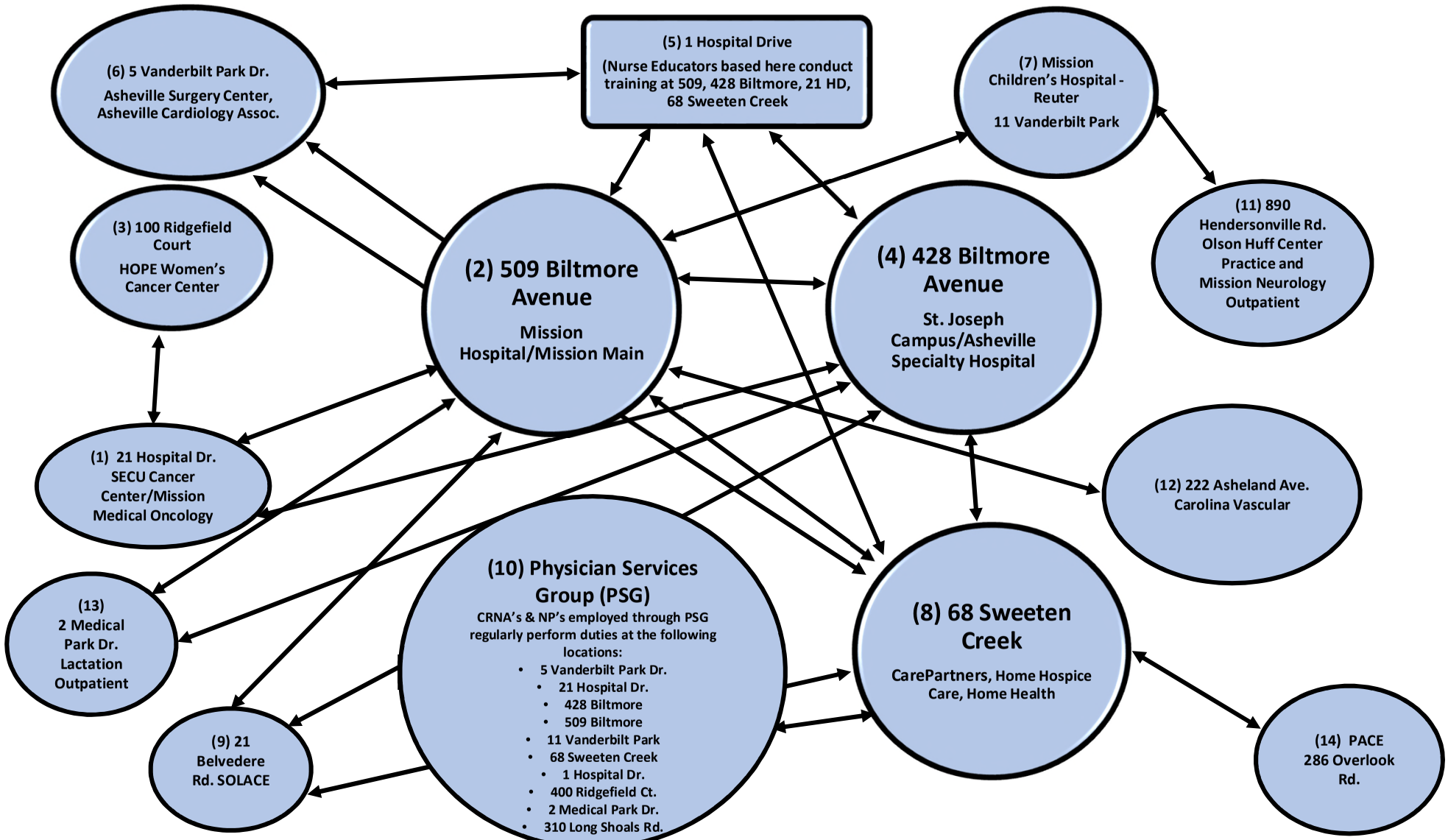
APPENDIX B

EMPLOYEE INTERCHANGE

NUMBER	PRIMARILY WORKS AT:	ALSO WORKS AT:	TRANSCRIPT REFERENCE
1.	21 Hospital Drive – SECU Cancer Center	509 Biltmore Ave – Mission Main; 428 Biltmore – Asheville Specialty Hospital; 100 Ridgefield Ct. – HOPE Women's Cancer Center; 21 Hospital Drive – Mission Medical Oncology	Tr. 489:14-25, 490:1-21, Tr. 490:21-25, 491:1-5, Tr. 485:1-25, 486:1-11, Tr. 485:22-25, 486:1-11, 20-25, 487:1-10
2.	509 Biltmore Avenue – Mission Hospital/Mission Main	21 Hospital Drive – SECU Cancer Center; 5 Vanderbilt Park Dr. – Asheville Surgery Center; 5 Vanderbilt Park Dr. – Asheville Cardiology Associates; 11 Vanderbilt Park Dr. – Mission Children's Hospital "Reuters"; 68 Sweeten Creek - CarePartners; 21 Belvedere Rd. - Solace; 2 Medical Park Dr.; 428 Biltmore Ave – St. Joseph's Campus/Asheville Specialty Hospital	Tr. 468:20-25, 469:1-3, Tr. 356:22-25, 357:1-2, Tr. 316:21-25, 317:1-25, Tr. 312:24-25, 313:1, 316:21-25, 317:1-18, Tr. 1129:3-5, Tr. 1130:21-25, 1131:1, Tr. 1217:4-13, Tr. 1244:7-10, Tr. 1244:11-16, Tr. 1244:17-25, 1245:1-3, Tr. 1245:20-25, 1246:1, Tr. 1088:25, 1089:1-25, 1090:1-2, Tr. 988:6-25, 989:1-2
3.	100 Ridgefield Court – HOPE Women's Cancer Center	21 Hospital Drive – SECU Cancer Center/Mission Medical Oncology	Tr. 485:22-25, 486:1-11, 20-25, 487:1-10,
4.	428 Biltmore Avenue – St. Joseph Campus/Asheville Specialty Hospital	509 Biltmore Ave – Mission Main; 68 Sweeten Creek – CarePartners; 1 Hospital Dr.; 2 Medical Park Dr.	Tr. 1087:23-25, 1088:1-3, Tr. 357:8-24, Tr. 1216:6-25, Tr. 1217:4-13, Tr. 987:17-25, Tr. 988:6-25, 989:1-7, Tr. 989:19-22
5.	1 Hospital Drive	5 Vanderbilt Park Dr. – Asheville Surgery Center; 428 Biltmore Ave – St. Joseph's Campus; 509 Biltmore Ave – Mission Main	Tr. 372:6-25, 373:1-8, Tr. 373:9-25, 374:1-20, Tr. 937:9-22, Tr. 60:8-25, 61:1-9; Er. Ex. 3, pp 11-12 and Ex. 4, p 1, Tr. 994:20-25, 995:1-4, 996:17-23, Tr. 1051:17-25, 1052:1-24, Tr. 360:1-17, 1049:6-20, 1221:22-24
6.	5 Vanderbilt Park Drive – Asheville Surgery Center & Asheville Cardiology Associates	509 Biltmore Ave – Mission Main; 68 Sweeten Creek; 1 Hospital Dr.	Tr. 353:24-25, 354:1-23, Tr. 357:8-24, Tr. 350:6-14, Tr. 376:19-25, 377:1-2, Tr. 372:6-25, 373:1-8, Tr. 670-683, Er. Ex. 16, Tr. 292:15-25, 293:1-2; Tr. 1217:4-13,
7.	11 Vanderbilt Park Drive – Mission Children's Hospital – Reuter's	509 Biltmore Ave – Mission Main	Tr. 319:1-5, Tr. 321:7-25, 322:1-2, Tr. 1029:20-25, 1030:1-16; 1031:3-25, 1032:1-25, 1033:1-24

EMPLOYEE INTERCHANGE

NUMBER	PRIMARILY WORKS AT:	ALSO WORKS AT:	TRANSCRIPT REFERENCE
8.	68 Sweeten Creek – CarePartners	509 Biltmore Ave – Mission Main; 428 Biltmore Ave – St. Joseph's Campus/Asheville Specialty Hospital; 286 Overlook Road – PACE; Other PSG Locations; 1 Hospital Dr.	Tr. 1161:2-4, Tr. 1161:10-25, 1162:1, Tr. 1288:21-25, 1289:1:11, Tr. 1293:2-1293:12, Tr. 1293:20-25, 1294:1, Tr. 1168:18-1169:22, Tr. 598:20-25, 599:1-23, Tr. 599:24-25, 600:1-5
9.	21 Belvedere Rd. – Solace Center – Inpatient Hospice	509 Biltmore Ave – Mission Main; 68 Sweeten Creek - CarePartners; 428 Biltmore Ave. – St. Joseph's Campus/Asheville Specialty Hospital	Tr. 1101:5-9, 1102:12-19, Tr. 1101:10-17, Tr. 1102:20-23, Tr. 1136:22-25, 1137:1-25, 1138:1, Tr. 1148:15-19, Tr. 1245:20-25, 1246:1, Tr. 1244:17-25, 1245:1-3
10.	**Physician Services Group: CRNAs & NPs employed through PSG regularly perform duties at and among the following locations:** 509 Biltmore Ave – Mission Main; 428 Biltmore Ave – St. Joseph's Campus/Asheville Specialty Hospital; 21 Hospital Dr. – SECU Cancer Center; 5 Vanderbilt Park Dr. – Asheville Surgery Center & Asheville Cardiology Assoc.; 11 Vanderbilt Park Dr.; 1 Hospital Dr.; 68 Sweeten Creek - CarePartners; 2695 Hendersonville Road – Vista Family Health; 41 Oakland Road – Asheville Family Medicine; 63 Monticello Road – Mission Family Medicine; 900 Hendersonville Road – Mission Infectious Disease; 222 Asheland Ave; 310 Long Shoals Rd.		Tr. 58:23-25, 59:1-25, 60:1-25, 61:1-9, Tr. 77:18-22; 459:24-25, 460:1-6; Er. Ex. 3, Tr. 671:1-7, 23-25, 672:1-25, 673:1-22, 674:2-20, 674:25, 676:1-20, 677:13-25, 678:8-25, 679:2-25, 680:1-10, 16-20, 683:3-14; see Er. Exs. 14, 15, 16, Tr. 670:24-25, 671:1-5; Er. Ex. 16, Tr. 651:22-25, 652:1-6, Tr. 653:3-19, Tr. 654:3-20, Tr. 655:13-25, 656:1-5, Tr. 567:3-23, Tr. 661:18-24, 662:13-19; Er. Exs. 3, 14, Tr. 662:20-25, 663:2-17, Er. Ex. 14, Tr. 1307:19-23, Tr. 1307:24-25, 1308:1-9, Tr. 253:2-25,. 254:1-25, 255:1-4, 662:20-24, 663:3-24, 667:17-25, 668:1-14; 1308:17-25, 1309:1-7 Er. Exs. 3, 14-15
11.	890 Hendersonville Road – Houses Olson Huff Center Practice and Mission Neurology Outpatient	11 Vanderbilt Park Drive – Mission Children's Hospital – Reuter's	Tr. 261:22-25, 262:1-14, 293:13-25, 294:1-25, 871:22-24, Er. Ex. 3, p 13
12.	222 Asheland Avenue – Carolina Vascular	509 Biltmore Ave – Mission Main; 310 Long Shoals Rd. – My Care Now & Vein Clinic	Tr. 253:2-25, 254:1-25, 255:1-4, 662:20-24, 663:3-24, 667:17-25, 668:1-14; 1308:17-25, 1309:1-7 Er. Exs. 3, 14-15
13.	2 Medical Park Dr. – Lactation Outpatient	509 Biltmore Ave – Mission Main; 428 Biltmore Ave – St. Joseph's Campus	Tr. 987:17-25, Tr. 988:6-25, 989:1-7, Tr. 989:19-22
14.	286 Overlook Road – PACE	68 Sweeten Creek - CarePartners	Tr. 1129:6-12, Tr. 1314:10-24


(6) 5 Vanderbilt Park Dr.
Asheville Surgery Center, Asheville Cardiology Assoc.
(5) 1 Hospital Drive
(Nurse Educators based here conduct training at 509, 428 Biltmore, 21 HD, 68 Sweeten Creek
(7) Mission Children's Hospital - Reuter
11 Vanderbilt Park
(3) 100 Ridgefield Court
HOPE Women's Cancer Center
(2) 509 Biltmore Avenue
Mission Hospital/Mission Main
(4) 428 Biltmore Avenue
St. Joseph Campus/Asheville Specialty Hospital
(11) 890 Hendersonville Rd. Olson Huff Center Practice and Mission Neurology Outpatient
(1) 21 Hospital Dr. SECU Cancer Center/Mission Medical Oncology
(12) 222 Asheland Ave. Carolina Vascular
(13) 2 Medical Park Dr. Lactation Outpatient
(10) Physician Services Group (PSG)
CRNA's & NP's employed through PSG regularly perform duties at the following locations:
• 5 Vanderbilt Park Dr.
• 21 Hospital Dr.
• 428 Biltmore
• 509 Biltmore
• 11 Vanderbilt Park
• 68 Sweeten Creek
• 1 Hospital Dr.
• 400 Ridgefield Ct.
• 2 Medical Park Dr.
• 310 Long Shoals Rd.
(8) 68 Sweeten Creek
CarePartners, Home Hospice Care, Home Health
(9) 21 Belvedere Rd. SOLACE
(14) PACE 286 Overlook Rd.